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ABSTRACT

A rationale for early childhood and parent involvement programs is provided in this volume, along with guidelines and examples of how to proceed. Each of its nine chapters includes a bibliography. Chapter 1, "Rationale for Early Intervention," examines such topics as the importance of the early years, teaching parents to intervene, and cost effectiveness. Chapter 2, "Program Administration," covers identification, responsibilities of the coordinator/director, confidentiality, medication, and other topics. Philosophy, staffing pattern, theoretical models, and the child and the environment are discussed in chapter 3, titled "Conceptualizing and Developing a Program." Chapter 4, "Coordinating Community Resources," looks at a rationale for interagency coordination, overcoming barriers, and the data collection process. Among the topics considered in chapter 5, "Screening and Assessment," are screening, the IEP (individual program plan), and appropriate evaluation procedures. In chapter 6, "Curriculum," sections look at major program areas, social/emotional sequences, and the gifted handicapped. Chapter 7, "Parent Involvement," examines the effect of a handicapped child on the family system, problem-solving counseling, parent advisory committees, and other topics. Chapter 8 is titled "Staff Development" and chapter 9 covers "Evaluation." The manual includes a glossary of about 40 terms. Appendix A describes funding sources and appendix B gives examples of evaluation forms. (JC)

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THE COLORADO GUIDELINES

FOR

PRESCHOOL SPECIAL EDUCATION PROGRAMS

EC151062

THE COLORADO GUIDELINES
FOR
PRESCHOOL SPECIAL EDUCATION PROGRAMS

Dr. Toni Linder
University of Denver

Brian A. McNulty, Supervisor, Special Education Services
Dr. Peter S. Fanning, Executive Director, Special Education Services
Dr. Edwin E. Steinbrecher, Assistant Commissioner, Special Education Services
Dr. Calvin M. Frazier, Commissioner of Education

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To all of these, thank you. I hope that the final product of all of these efforts will contribute in some small way to better the lives of handicapped children and their families.

FORWARD

The documentation of the effectiveness of early childhood programs for handicapped children has been substantial. Not only are some of the effects of stress associated with prematurity and low birthweight alleviated, but the lives of sensory-impaired infants can be markedly improved. It is well known that early treatment and training of deaf and blind children before 2 years of age can assist these children in living very normal lives, and it is suspected that similar results have impact on other developmentally disabled children.

Further, the impact of early childhood programs on children who reside in poverty alters the typical negative course of their lives. Strong effects of early interaction have been found in studies in Michigan, Florida, New York, Wisconsin, and other areas of the world. Homestart and Head Start have demonstrated that the child who resides in poverty has the genetic potential to meet the requirements of the culture and to function within it. One of the keys to the success of these programs is the attention given to strengthening the family of these children so that facilitating childrearing and stimulation strategies are put into practice.

The focus of recent efforts of early childhood programs for the handicapped has been to involve the family and thereby serve the child through the family. In contrast, public schools have not focused on early childhood programs and the involvement of parents to strengthen the family. For those public schools who wish to begin early childhood and parent programs, there has been a lack of comprehensive materials to enable schools to establish programs based on standards of excellence.

The remediation of this lack is what Dr. Linder has accomplished in this manual. She has provided a cogent rationale as to why early childhood and parent involvement programs are needed, and, further, she has provided guidelines and examples of how to proceed. In this manual you will find attention paid to all aspects of program development from administration, evaluation and curriculum to coordination of services. It is hoped that the implementation of programs based on the ideas contained here will greatly assist many handicapped children and their families to live richer and fuller lives.

Nicholas J. Anastasiow, Ph.D.
Professor of Psychiatry
Associate Director for Research
John F. Kennedy Child Development Center
Department of Psychiatry
School of Medicine
University of Colorado

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ONE

RATIONALE FOR EARLY INTERVENTION

A PARENT'S PERSPECTIVE

"You asked what early intervention has meant to my handicapped son and our family. Words are insufficient to express feelings, but I will try. Jason has been involved in infant and preschool programs for four years. During that time his program has meant honesty, hope, and help. Honesty - because warm, sensitive, caring staff gave us the first really honest information about our son's developmental delays. But at the same time they encouraged us and gave us hope for his future. During the last four years they have provided continual support and helped us to understand how best to work and play with Jason, helped us to see his strengths as well as his weaknesses, and helped us to observe his progress.

As for our family, there are times I really feel that without the early intervention program we would not even have a family. The stresses of having a handicapped child are great. The program provided a means by which my husband and I could, along with other parents, share and work through our feelings about having a handicapped child. There were days when I felt I could not go on, but supportive staff were there to encourage and occasionally take over. We went through some very tough times but we have grown. Jason has grown and is doing well. Our other children have grown and I think are more accepting and sensitive to differences in people. And my husband and I have also grown and now feel that we can offer support to other families of handicapped children. In addition, we have become more concerned as citizens and stronger advocates of human service issues.

What has early intervention meant to my handicapped son and our family. It has meant a more productive and promising life."

Anonymous Parent, 1980

The thoughts expressed by this parent of a young handicapped child are warm testimony to the effectiveness of early intervention. They serve to underline the positive impact a program can have both for young handicapped children and for their families. The significance of early intervention is undeniable.

THE IMPORTANCE OF THE EARLY YEARS

Evidence of the critical importance of the early years of life has been steadily mounting. Emperical research findings demonstrating the effects of early experience on animals has been utilized as a basis for inferences regarding the importance of the early years to human infants. Studies on children reared in "deprived" environments have also revealed the long-term impact of early environmental conditions. In addition, research in motor, cognitive, language, social and emotional development has contributed to our understanding of the interactive nature of the areas of development. Researchers and theorists are developing conceptual frameworks for analysis of learning and application of developmental principles. This expanding knowledge base has influenced both social and political trends toward early intervention for handicapped infants and pre-schoolers.

ANIMAL RESEARCH

In animal research, studies of Lorenz (1971), Harlow (1974), Denenberg (1969) and others, have demonstrated that the procedures used in raising an animal from infancy have profound effects upon its behavior and physiology in adulthood. The effects of environmental conditions such as light (Hebb, 1937; Riesen 1961), tactile, kinesthetic, and manipulative experiences (Levine, 1966; Nissen, Chow and Semmens, 1951), nutrition (Hall, 1956), amount and type of stimulation (Carmichael, 1927; Thompson and Melzack, 1956; and Rosenweig, 1966) have been shown to affect later cognitive functioning in animals. Research on human babies has looked at similar factors. The impact of material deprivation (Bowlby, 1969; Dennis, 1960; and Spitz and Wolff 1946), nutrition, environmental modification through visual, auditory, tactile, or vestibular stimulation (Scarr-Salapatek and Williams, 1972) have been examined. Both animal and human studies have revealed the early plasticity of the brain and the possible reversibility of negative environmental effects. Novak and Harlow (1975), Denenberg (1976), and others have demonstrated the reversibility of early damage to animals. Dennis (1960), Skeels and Dye (1939), have shown that early damage as a result of environmental deprivation can be ameliorated.

HUMAN RESEARCH

Many scholars have examined the plasticity of the human organism in the early years and the effects that the environment can have on increasing potentiality. Hunt reviewed literature on the effects of experience on intelligence and stated, "The assumption that intelligence is fixed and that its development is predetermined by the genes is no longer tenable" (p. 342). It might be feasible to discover ways to govern the encounters that children have with their environments, especially during the early years of their development, to achieve a substantially faster rate of intellectual capacity."

Bloom (1964) investigated the appropriateness of early intervention by examining fifty years of child development studies. He concluded that the studies "make it clear that intelligence is a developing function and that the stability of measured intelligence increased with age...in terms of intelligence measured at age seventeen, about 50 percent of the development takes place between conception and age four" (p. 88). Northern and Downs (1974) have referred to the preschool years from ages three to six as "critical years... during which language is learned." (p. 224). They are in agreement with Jensen (1967), that "our present knowledge of the development of learning abilities indicates that the preschool years are the most important years of learning in the child's life...and this learning is the foundation for all further learning" (p. 125).

In terms of capacity, Roos (1974) has stated that by age eight, children have obtained 80 percent of their total intellectual capacity. Research seems to support that the best time to attack a child's mental physical or emotional handicap appears to be the years from birth through early childhood (Roos, 1974, Lillie, 1975).

Evidence continues to support not only the importance of the early years for learning, but also the critical nature of the early years for intervention with handicapped children. As La Cross, et. al. (1970) has indicated, "if we are certain of nothing else, we can at least be reasonably sure of the plasticity of early human development and the value of early stimulation."

NEGATIVE EFFECTS FROM LACK OF INTERVENTION

Ausubel (1964) and others (Bloom, 1964, Bruner, 1972) have noted that failure to provide remedial programs for disadvantaged and handicapped children in their early years, tends to result in "cumulative developmental deficit."

All areas of development are interrelated and thus a problem in one area has an effect on each of the others. For example, a physical handicap can limit the child's mobility within his environment and can restrict the child's opportunities to interact with objects, events and people. Limited interaction may result in reduced understanding of relationships (both physical and cognitive) between objects, events, and people with a consequent diminished capacity for problem-solving. Thus, cognitive, language, and social development may also be impaired or delayed. Any handicap may have deletorious effects on all areas of development (see chapter 6 for further discussion of the interrelated nature of developmental areas). Failure to intervene may allow the affects of the handicap to be compounded. Piaget, Gesell, Strauss, Kephart, and Barsh have each emphasized the essential relationship between early sensorimotor development and later developmental integrity. There is also general agreement that failure to attain social and/or problem-solving skills early in life may have a detrimental effect on later emotional development.

The presence of a handicapped child in the family places great stress on the member who is at the same time an individual, a marriage partner, and a parent (Carver and Carver, 1972; Ehlens, 1966; Jacobs, 1969; Farber, 1965). Forbes (1958) has described the dependency of a handicapped child in terms of "prolonged infancy." This dependence may produce a conflict over the desire for freedom and a "normal" life and the feeling of responsibility and duty to the handicapped child. In addition, many handicapped infants may not provide the responses to mothering (or fathering) which normally reinforce the parents's positive interactions with their child.

Brazelton (1963), observing the interaction of "difficult" infants and their mothers, has noted the strong influence of the baby's behavior in determining the nature of the child-parent relationship. If the child does not respond to or does not demonstrate, smiling, laughing, touching, seeking out behaviors which are rewarding to parents, the parents may begin to withdraw from interaction with the child. On the other hand, the child may have many negative, aggressive, or self-damaging behaviors which the parents are unable to control. Negative cycles of behavior develop which may cause anxiety and despair on the part of the parents. In addition, financial burdens often accrue. The frustration, guilt, and anger parents feel have been confirmed as universal emotional responses (Noland, 1970). When support systems are unavailable to the family, the consequence is often a family in crisis, a dissolution of the family, or the placement of the child in an institution. The social and economic implications of these factors should not be overlooked.

POSITIVE EFFECTS OF EARLY INTERVENTION

Much of the available research on the effects of early intervention can be traced to programs which were initiated to remediate or prevent learning problems which result from the child's early environment. Caldwell (1970) concludes "differences on most cognitive variables can be demonstrated as a function of an early childhood spent in environments presumed to differ in the amount and quality of available stimulation" (p. 179).

There is evidence that some handicaps, especially mild mental retardation, are highly influenced by environmental factors. Cultural-familial retardation or CFR (Giradeau, 1971) refers to disorders in which the individuals in a family experience retarded development without an observable biological basis. Zigler (1967) notes that CFR accounts for about 75 percent of the retarded population. Conley (1973) states "a more stimulating environment could enable over half of the retarded to achieve I.Q. scores above arbitrary cut off point (for mild retardation) of 70" (p. 321). Although using I.Q. scores as cut-off points for determination of a handicap is a questionable practice, there is much documentation demonstrating the increase in ability and adaptive performance level of young developmentally delayed children who have been involved in intervetion programs. In perhaps one of the most comprehensive studies of the effects of early intervention, Lazar, et. al. (1977) summarized the findings of the Developmental Continuity Consortium, a collaborative effort of twelve research groups conducting longitudinal studies on the outcome of early education programs for low-income infants and preschool children. Three important results were reported: 1) early education significantly reduced the number of children assigned to special classes; 2) early education reduced the number of children held back one or more grades; and 3) children surpassed their control group on I.Q. tests.

In the Milwaukee Project (Heber, Garber, Harrington, Hoffman, and Falendar, 1975), families of selected low-income children with mothers of subnormal I.Q., were provided intensive support from the child's birth to school age. The families were helped to develop survival skills and at the same time were taught good parenting skills. The results showed that children participating in the project had at least normal intelligence and the group average was at least one standard deviation above the mean. This type of evidence supports the premise that environmental stimulation and parent education can be tremendously beneficial to children at risk for developmental and/or school related problems.

For the handicapped child there is mounting evidence to suggest early intervention is not only beneficial it is crucial. Alice Hayden and her colleagues at the Model Preschool Center for Handicapped Children at the Experimental Education Unit have demonstrated that Down's Syndrome children who were at one time thought to be "trainable" or institutional candidates, can with intensive early intervention, function at a low-average level of intelligence. They can be mainstreamed successfully with normal peers, and they can learn such academic tasks as reading (Hayden and McGuiness, 1977). Roos (1974) cites evidence to support his contention that, for retarded children, "programs of early education seem particularly crucial if the individual is to be given the opportunity of reaching maximum potential" (p. 243). Other programs (Bricker, 1977; Karnes, 1973; Weikart, 1971) have shown that early intervention can be critical not only to the progress of the child but also to the maintenance of the family.

Parents have indicated that they need support in accepting the child's disability, overcoming misconceptions about the handicap, learning sensible limitations, and planning appropriate educational experiences for the child. If given support and encouragement the parents become the child's most important teacher. In the many valuable hours that the child is not in a program, the parent can follow-up on educational programs and therapy techniques and modify the environment in such a way as to best facilitate interaction and incidental learning. More important, the parents can learn how to play with their handicapped child. The sensory cues and reinforcements which the normal infant brings to the parent-child interaction may be lacking in the handicapped child (Cichetti, and Sroufe, 1975). Without the support and guidance of professionals, parents may not be able to detect the individual cues of the child and thus may fail to foster social interaction. This social interaction is crucial as the parent is the mediator of the child's environment and the interactions the child has with and within his/her environment. The intervention staff can facilitate increased adult attention to the child's needs and his/her strengths as well as weaknesses. Reingold and Bayley (1959) pointed out that an increased amount of adult attention appears to raise the degree of immediate social responsiveness in handicapped children as well as to increase their abilities to develop speech skills.

It is generally agreed that for the hearing impaired child the early years are critical in terms of language development. Downs (1971) speaks of the years from birth to three as the "formative years that will ultimately shape the educational course the child will take by the age of three or four." The development of language is closely related to the development of cognition. An inability to understand word meanings and uses hinders the acquisition of concepts and the use of those concepts in problem-solving, as the child is no longer bound to physical expression of emotions. Thus, for the handicapped child who is often language delayed, early intervention can enable the child to acquire skills which will enhance his/her development in other developmental areas as well.

The visually impaired child is also one who may not interact with the environment in ways which will encourage developmental growth. Barraga (1976) and Fraiberg (1977) have pointed out the importance of a wide range and variety of concrete experiences early in life for the visually handicapped child. The child can be taught how to compensate for deficits, to explore and interact with objects, people and events within his environment. Without this intervention the child may develop self-stimulating behaviors, may withdraw from motor activities, may encounter social difficulties and/or behavioral problems. For all handicapped children, fostering the development of compensatory modalities will enable them to utilize strengths to build on weaknesses. For some specific handicaps, such as cerebral palsy, the "early treatment..produces better results than treatment postponed until motor patterns and habits have been established" Koch (1958). For other handicaps this is true as well. Undesirable behavioral, motor, and language patterns can be altered before they have a compounding effect on developmental delay.

Early intervention programs can alter the social environment, provide increased concrete sensory motor experiences, and lay the ground work for optimum physical, intellectual and emotional development. Such early intervention can eliminate or reduce the severity of many disabilities. For example, specific learning disabilities relating to input, processing, and output of language can often be remediated prior to the child's encountering severe learning deficiencies which will affect the self-concept and academic progress in school (Francis-Williams, 1974; Wallace and McLoughlin, 1975).

BENEFITS FOR FAMILIES

The benefits of early intervention programs for the family are many:

1) The intervention program staff can offer emotional support to families in times of difficulty or crisis.
2) The intervention program staff can help parents understand the handicapping conditions, the strengths and weaknesses, and program needs of

their child.

3) The intervention program staff can offer suggestions, demonstrate, model, and teach parents how to intervene on behalf of their child.

4) The intervention program staff can offer educational programs to increase a parent's knowledge and skills in areas relating to the parent's or child's needs.

5) The intervention program staff can aid parents in obtaining needed services and resources to allow the family to maintain the child in the home and be able to provide for his/her needs.

6) The intervention program can facilitate the development of positive attitudes toward the school system.

EMOTIONAL SUPPORT

The birth of a handicapped child can have profound effects upon the family. The parents may go through stages similar to those that dying persons experience as discussed by Elizabeth Kubler-Ross (1969). Denial, anger, guilt, the search for a cure, are many times stages that parents of a handicapped child also experience. Parents often need help in working through these feelings before they can adequately relate to their child. Early intervention programs can offer that support. Parents also need support in times of crisis. When the child needs surgery or is hospitalized, families can benefit from staff concern and assistance. When the family structure changes, through death, divorce, or the addition or loss of a family member, emotional support can help maintain stability. When the child is being evaluated or is changing placements, the parents need assistance in understanding terms, processes, and procedures. Early intervention staff are important allies for families in times of crisis in the lives of handicapped children.

UNDERSTANDING THEIR CHILD

Early intervention staff can help parents to understand their child's handicap and the implications of the handicap both to the child and to the family. Labels such as mentally retarded, brain damaged, emotionally disturbed, etc. are all vague meaningless terms. They are connatatively "loaded" depending on a variety of factors such as, background, experience, values, knowledge. Parents can be helped to understand the child's deficits through descriptive analysis of developmental areas. Such description can facilitate the parents understanding of their child's specific information about what they can do to help the child. As educators, we have an ethical responsibility to not only diagnose but to serve handicapped children and their families.

TEACHING PARENTS TO INTERVENE

The handicapped child's primary caretakers undoubtedly spend more time than anyone else with the child. Thus, it makes sense for parents to be provided with suggestions for follow through at home while engaged in normal activities of daily living. Parents can be shown how to make environmental modifications to enhance the child's interaction with the people and objects in his/her environment. Specific recommendations relating to developmentally appropriate activities can be made depending on the individual needs of the child. Bronfenbrenner (1975) has examined the successfulness of early intervention programs and determined that those which directly involve parents as part of the team are the most successful. Parents want and need information about how to help their handicapped child.

PARENT EDUCATION

In addition to needing information about meeting their child's needs, parents often need information to help them meet their own needs. In fact, many times the parent is unable to meet the child's needs until basic survival and psychological needs are met first. Early intervention staff can do much to increase parents' knowledge and skills in areas which are important to them. When parents are able to cope with and handle the daily problems of life, they are then freed to concentrate on improving parenting skills. Improving communication skills, parenting skills, etc. has been shown to have a positive affect on subsequent children (Heber, et. al 1975) as well as on the child for whom intervention is planned. The new skills which are acquired are generalized to the younger siblings. Thus the benefits to society are multiplied when we see the possibility of reducing problems associated with poor parenting - such as child abuse and neglect.

COORDINATION OF SERVICES

The maze of agencies that many parents must deal with in getting services for their child is often overwhelming. Parents frequently become frustrated with "getting the run-around," vague promises, lack of follow-through and inaccurate or conflicting information. Early intervention staff can play an important role in advocating for the family and helping to coordinate services. Often their knowledge of agency policies and procedures can reduce the amount of waiting parents must endure to obtain needed services. Staff can also provide needed information concerning legal rights and responsibilities of agencies.

ATTITUDES TOWARD SCHOOL SYSTEM

Lazar (1977) has reported that early intervention programs can change parents' attitudes toward the school system. Many parents of children involved in Head Start programs, for example, had negative attitudes about the importance of education, probably as a result of negative personal experiences when they were children. After being involved with early intervention programs which were warmly supportive and encouraging, most parents held positive views about schools and education. This may be a very important factor for children at risk for school failure and dropping out of school. With parental support for schools, such children may remain in school longer. More importantly, parents may not fear the school and may begin to work with teachers to increase the child's skills. The attitude and values of the parents strongly affects the attitude and values of the child. A positive attitude on the part of parents can do much to encourage positive attitudes on the part of children. Lazar (1977) has also noted that increased parental concern and competence to deal with the school system is an indirect effect of parental sensitization as a result of the preschool experience of their children.

EFFECTS OF EARLY INTERVENTION ON SOCIETY

Educational trends are highly influenced by political events of the period. Attitudes toward the handicapped have followed a similar pattern to the attitudes of society toward its other minority groups. Minority groups have evolved through a historical pattern from societal shunning, to "separate-but-equal", to integration with priority standing. As Caldwell (1973) has pointed out attitudes toward services for the handicapped have evolved from a "forget and hide" approach to a "screen and segregate" attitude to the present attitude of "identify and help." The courts have continued to uphold decisions in favor of civil rights and right to education and treatment.

State and Supreme Court rulings have called for the equal education of all children (Abeson, 1974, Ross, DeYoung, and Cohen, 1971). Zedler (1974) interprets these rulings to mean that each child should receive education which is appropriate for his abilities. If a state fails to provide appropriate education, parents may use legal means to obtain necessary services for their children.

National legislation has been passed to encourage the development of early education programs. The 1969 Elementary and Secondary Education Act Amendments, Title VI (Public Law 91-230), has made early education fiscally possible. The Economic Opportunity Act of 1972 required that 10% of Head Start children served be handicapped. The Handicapped Children's Early Education Assistance Act and Model Centers Program allowed model programs to be developed and research to be done which has substantiated the effectiveness of early education. Public Law 94-142, the All Handicapped Childrens Act of 1975 has mandated the identification of handicapped children down to birth and education of handicapped children down to three years old (when not inconsistent with state laws). State Implementation Grants and Preschool Incentive Grants have been funded yearly to encourage and foster the development of state-wide early childhood programs for young handicapped children.

The National Education Association, the 1974 National Governor's Conference, the Council for Exceptional Children, and many other organizations and groups have publically endorsed early education programs for the handicapped. Clearly society's attitudes toward services for its handicapped members have taken a dramatic positive turn. All branches of our government, executive, judicial, and legislative, have seen the worth of the education of its young handicapped citizens- the trend is toward increasing services for all handicapped children of all ages.

As previously discussed, there is mounting evidence to support the positive effects of early intervention. There is also evidence that there will be an increasing number of children needing early intervention. Several factors may contribute to this increase. 1) The growing number of teen-aged mothers increases the number of children who are likely to be at high risk for problems as well as suffer from abuse and neglect; 2) More premature and small for gestational age babies are surviving. These babies have a greater risk of central nervous system damage, mental retardation, malnutrition, and motor and language difficulties; 3) Medical technology has also made possible the survival of severely involved children who previously would have died; 4) State and national efforts to deinstitutionalize and keep handicapped children at home will necessitate support services to families to enable them to maintain their child and keep their family intact. 5) Child find, mandated by P.L. 94-142, is identifying handicapped children down to birth.

COST EFFECTIVENESS

The previously discussed benefits to child and family are the most immediate and measureable benefits. Other benefits may not be as visible, but can have profound long-range benefits to society.

Education programs for handicapped children cost money. The costs increase as the programs become more segregated and restrictive. Therefore, it makes fiscal sense (as well as philosophical sense) to provide services to handicapped children in the least restrictive environment possible. Weikart (1971) suggests that early intervention may make it possible for a child to move into regular educational programs earlier than the child who receives no "early" assistance.

Lazar (1977) concludes in his review of program effectiveness, "Infant and preschool services improve ability of low income children to meet minimal requirements of the school they enter. This effect can be manifested in either a reduced probability of being assigned to special classes or a reduced probability of being held back a grade. Either reduction constitutes a substantial cost reduction for the school system" (p. 19). Hodges, McCandless, and Spicker (1967) reported similar results with disadvantaged mentally retarded children.

These cost benefits to the education system are significant, but even more important and long-term societal advantages are to be gained. Closer Look has analyzed the pay-off of education. "Handicapped people who are given an appropriate education repay the costs of that education in actual taxes, within 5 years, and they go on paying taxes and producing products or services over their lifetimes, instead of depending on society to support them." And what becomes of the handicapped who do not receive an appropriate education? Society pays through its taxes for supplemental security benefits, welfare or in some cases long-term institutionalization.

In 1973 Conley had estimated the lifetime costs of maintaining a person in a state institution at $500,000, with current rates of inflation and cost of living, this figure is now much greater. But how do these bleak figures relate to early intervention? It is necessary to review previously demonstrated tenets to illustrate the syllogistic reasoning.

1) the early years of life are vital learning years and provide the foundations for later learning;
2) cumulative and/or compounded deficits can be reduced with early education;
3) parents can be the most effective teachers when they are helped to cope and taught how to facilitate their child's development;
4) early intervention results in placement in less restrictive environments;
5) less restrictive environments are more cost effective.

Therefore:

Early intervention takes advantage of the crucial learning years to reduce cumulative negative effects of the handicap. It supports family maintenance of the child, and results in cost benefits to society.

EARLY INTERVENTION-WHY IN PUBLIC SCHOOL?

In the past a variety of community agencies have provided services to young handicapped children. Head Start, community centers, East Seal Centers, and other public and private agencies have lead the way in providing needed services to handicapped infants and preschoolers and their families. These organizations are funded by multiple methods, including federal, state and local support, private contributions and tuition fees (not to mention the ubiquitous bake sale and fund raiser). Each of the agencies which contributes to the programs has its own set of policies, procedures and monitoring methods. Requirements for these different agencies are not only diverse, they are often in conflict. Standards for health and safety, student-teacher ratios, testing and evaluation and bookkeeping may differ greatly from agency to agency. In some cases conflicts arise over funding responsibility. On one hand dual funding may occur, or on the other hand no agency may claim responsibility for funding particular services. Gaps and duplications of services are not uncommon. For example, departments of social services, institutions, and education may all have screening, identification and assessment responsibilities which they carry out totally independent of each other.

Early intervention programs could be coordinated and more efficiently and effectively administered if they came under the auspices of one public system. The public schools are the logical service providers to assume this responsibility.

First they are the only legislatively based, longitudinal, taxpayer-funded educational institution in the country. With both federal and state legal mandates, public schools have a basic continuing philosophy and funding source. With 16,000 school districts throughout the United States public schools can provide the means by which to respond to the needs of handicapped children in nearly every community throughout the country. This national school system in effect could provide a network for communication, and a mechanism for exchange and replication of exemplary projects and successful practices. With the increasing difficulty in obtaining private funding resources, the local tax base may become the most viable long-range resource. This local tax-base is historically the fundamental base for funding the public schools, and may, in difficult times, be the only reliable source of support.

The public schools are currently undergoing drops in enrollment which reflect the decrease in the birth rate. This decline in enrollment is leaving facilities empty which are appropriate facilities for early education programs. With increasing interests rates, the costs of building new facilities will be prohibitive and in most cases, agencies must rely on large private contributions to enable them to complete construction. The empty classrooms in public schools are logical sites for early intervention programs.

In addition to existing facilities, public schools have policies and procedures and standards which are well-accepted. If early education programs were under public schools, the need for meeting multiple sets of standards could be eliminated. Public schools have a system for hiring qualified staff which corresponds to certification requirements developed by experts in the state. There is presently a shortage of qualified staff to work with young handicapped children. Affiliation with public schools would help solve this problem, as states would develop competency standards for certification in early childhood special education. Institutions of higher education would respond by developing programs to train professionals in this area.

Public schools also have a layer of administration to develop inservice training and on-going professional development programs. Small, individual early intervention projects cannot afford this luxury. Professional development is either non-existant, minimal, or left to staff members to design on their own.

Resources are often available in a public school that are not affordable in private settings. Although many community programs have teams of specialists including speech therapists and occupational therapists, other support personnel such as mobility specialists, vision specialists, nurses, etc. may not be available. Public schools can justify the services of all needed support personnel through the legal mandate of P.L. 94-142.

One of the most important reasons for location of early education programs for handicapped children in the public schools is the desirability of a continuum of services with continuity and follow-through. Often when children come from other public agencies or private centers, there is a gap in the service system.

The program the child left took him to school age, where the schools picked him up. However, many times the programs do not afford a continuum, and the child doesn't quite "fit" the system. By including a total continuum of services within the public schools, the schools can provide the necessary transition from level to level with a continuity of philosophy and support services. Planning for the child's changing environments is essential, and such planning is facilitated when all parties are part of the continuum. The transition of records, individual program plans, and therapy programs is also expedited.

Public Law 94-142 has mandated a systematic process of identification, screening, assessment, program change, and continued evaluation. This mechanism ensures that the child's and family's due process rights are respected and that programs are designed to meet individual child and family needs. Placement of early intervention programs in public schools would provide legal safeguards for families of handicapped children.

Douglas Ritchie (1979) has outlined additional reasons why the public school system in Madison, Wisconsin has chosen to include early education programs.

1) Transportation is often the onus of small public and private early intervention programs. The public school system transportation system already exists and therefore eliminates one programmatic "headache."
2) Existing community programs often serve gargantuan areas, forcing child and family to spend a considerable amount of time traveling to and from the site. Public schools have numerous facilities within their district boundaries and program locations can be spread out or rotated to facilitate parent and child attendance.
3) Each local program currently has its own administrative structure. If consolidated with public schools some administrative efforts could be unified at the local building level.

4) It is easier to accumulate follow-up evaluation data on early childhood graduates if they remain in the same system. This is important to the individual program of every child, but is also important for monitoring total early intervention program effectiveness. Longitudinal studies for research purposes to gain needed knowledge in this burgeoning field would be facilitated.

Thus, in summary, inclusion of early childhood programs for handicapped infants and preschoolers in the public schools has many advantages. The child and family can benefit by a local continuum of services with legal guarantee of their rights and a continuing tax base for services. The taxpayers are benefited by a reduction in duplication of services and optimal employment of resources. The public schools are benefited through program supplementation, more effective service delivery system, and maximum staff utilization. As a field, early childhood special education is also benefited. Public schools provide a communication network, standards which will ensure qualified staff and encourage development of pre-service and inservice training programs, and they provide an on-going environment for research to benefit child, family and society.

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TWO

PROGRAM ADMINISTRATION

The Education for All Handicapped Children Act, Public Law 94-142, mandates a free appropriate public education for each handicapped child. Included in this important piece of legislation are the following mandates as outlined in the Special Education Administrative Policies Manual developed by the Council for Exceptional Children, (1977).

-All Exceptional Children and their parents shall be guaranteed due process with regard to identification, evaluation, and placement procedures.

-A written individualized educational program shall be developed for each child determined to have special needs.

-Educational placement decisions for each exceptional child shall always be in the least restrictive environment appropriate to the child's learning needs.

-Responsibility for providing the free appropriate educational program for each child rests with the local education agency.

-A periodic review shall be conducted by the agency at least annually to evaluate the exceptional child's progress and to rewrite the educational plan.

The law requires that handicapped children three years to twenty-one years of age be provided a free appropriate public education by September, 1980. The requirements for the three to five age range do not apply if the application of such requirements would be "inconsistent with state law or practice, or the order of any court". Colorado's legislation which is "permissive" down to birth, allows school districts to serve handicapped preschool children if desired. With the demonstrated need for services and documented benefits of early intervention, many public schools are choosing to take advantage of special incentive grant monies provided under P. L. 94-142 aimed at encouraging states to provide services for preschool age children.

In order to be eligible for monies allocated by the federal government, the local education agency (LEA) must provide written assurances which must include:

1) assurance of active ongoing child identification procedures;
2) assurance of a "full service" goal and detailed time table for implementation;
3) a guarantee of complete due process procedures;
4) assurance of an effective policy guaranteeing the right of all handicapped children to a free, appropriate public education, at no cost to parents or guardian;
5) assurance of non-discriminatory testing and evaluation;
6) assurance of the maintenance of an individualized education program(IEP) for each handicapped child;
7) assurance of special education being provided to all handicapped children in the "least restrictive environment";
8) a guarantee of policies and procedures to protect the confidentiality of data and information;
9) assurance of regular parent or guardian consultation;

10) assurance of a surrogate to act for any child when parents or guardians are either unknown or unavailable, or when the child is a legal ward of the State;

11) maintenance of programs and procedures for comprehensive personnel development, including in-service training.

IDENTIFICATION

The LEA needs to provide a clear, written description of each type of handicap for whom services will be provided. There is currently a controversy regarding the advisability of "labeling" a child with a particular category of handicap. The trend toward a non-categorical services aims at defining handicapped children by their special needs rather than by a specific handicapping condition. Colorado is currently providing services to handicapped children under the age five on a non-categorical basis. P.L. 94-142, however, requires that data be reported by the disability of the child. The following exceptionalities are designated (see Glossary for definitions):

- blind
- communciation disorder
- deaf
- deaf/blind
- developmentally disabled
- emotionally disturbed
- hard of hearing
- health impaired
- learning disabled
- mentally gifted(services not mandated through P.L. 94-142)
- mentally retarded
- multiple handicapped
- orthopedically handicapped

- talented (services not mandated through P.L. 94-142)
- visually impaired

Attempts at non-categorical services have variously grouped the handicapping conditions as:

- physical, health, or sensory handicaps
- emotional or behavioral problems
- exceptionality in mental ability

Designation of need for service by degree of severity of the handicap is another means by which states have tried to avoid stigmatizing labels:

- mildly handicapped
- moderately handicapped
- severely handicapped
- profoundly handicapped

Another method of grouping is by child needs which are then grouped by service. This is the current trend in Colorado, where the areas of need break out into:

- curricular needs
- training needs
- physical environmental needs
- classroom management needs
- social emotional needs
- vocational/avocational needs
- home-school interaction needs(see Figure 1, p. 30)

The handicap or "label" given to a child is a means by which to justify provision of services to the child and family. If trends continue, the future will, hopefully, see the development of a system which can justify the provision of services which address children's needs without the necessity of labeling a child.

COLORADO SPECIAL EDUCATION PROCESS

NEEDS

I. Curricular Needs

Does any of the student's regular curriculum need to be adapted or changed relating to:

- Method of Presentation
- ... modality
- ... rate
- Level of materials
- Type of equipment and materials

II. Training Needs

Does the student need specific adaptive or developmental training relating to:

- Use of residual hearing or vision
- Orientation and mobility
- Gross or fine motor skills
- Visual or auditory perception
- Speech sound production
- Receptive or expressive use of syntax, morphology, vocabulary
- Etc.

III. Physical Environmental Needs

Does the student need adaptations or changes in his physical environment relating to:

- Noise level
- Visual stimulation
- Physical accessibility
- Seating
- Lighting

IV. Classroom Management Needs

Does the student need alternative styles of teacher-student interaction relating to:

- Amount of structure
- Group vs. individual instruction
- Level of activity
- Behavioral management techniques
- Stress level
- Adaptive teaching techniques unique to hearing or vision handicap

V. Social Emotional Needs

Does the student's social/emotional environment need restructuring relating to:

- Peer relationships
- Self concept
- Knowledge and acceptance of his handicap or disability

VI. Vocational/Avocational Needs

Does the student have unique needs to his disability relating to:

- Economic and career awareness
- Realistic occupational goals
- Employability skills
- Recreational and leisure time activities

VII. Home-School Interaction Needs

Does the student need a revision in the home/school interaction relating to:

- Consistency
- Reinforcement of training or educational concepts

FULL SERVICE

It is the aim of P.L. 94-142 that educational agencies should provide a continuum of educational services which will enable children to be placed in the educational setting which is most appropriate to their needs. A variety of program alternatives should thus be available, so that children may benefit from placement in the "least restrictive" environment which will meet their needs. Deno(1977) has described a "cascade" of services from the least restrictive to the most restrictive, which includes most alternatives:

-Regular education with program modifications

-Consultative services

-Resource room

-Integrated programs

-Self-contained classes

-Diagnostic placement(not counted as placement)

-Homebound and hospitalized

In addition to placement in the appropriate educational setting, children are entitled to an individualized educational program and "related services" which will meet their unique needs and enable them to maximally benefit from their education. These related services include:

-occupational therapy

-nursing services

-physical therapy

-speech language services

-social services

-medical consultation

-counseling services

-psychological services

-transportation services

If the public school does not have the appropriate placement for a child, non-public day school programs or private settings can provide services. For states mandating services to handicapped children less than five years old, these non-public school services must be purchased. In states where pre-school and infant programs are not mandated, public schools may serve as the vehicle for identification and referral to appropriate placements. Public agencies receiving federal funds to which public schools refer young handicapped children should 1) meet the state standards that apply to local education agencies (LEA's); 2) maintain the child's I.E.P.; 3) accord the children and their families all rights as in public schools. If referrals are made to non-public schools, the school district has an ethical responsibility to provide follow-up and periodic re-evaluation.

LEADERSHIP IN EARLY CHILDHOOD SPECIAL EDUCATION

The coordinator/director of early childhood special education programs should be fully cognizant of all legal mandates and federal and state rules and regulations relevant to programs for young handicapped children. Early intervention programs are unique in that they are by necessity cross-agency and transdisciplinary. Leadership of early intervention programs thus necessitates highly knowledgeable and skilled individuals to plan, coordinate, implement and evaluate program efforts.

Leaders in early childhood special education need more than administrative skill. A belief in the effectiveness of early intervention and a commitment to young handicapped children and their families is essential. As in any new field there are many battles to be fought and obstacles to be overcome in the effort to actualize an ideal. A generous amount of dedication and fervor are required to maintain the necessary tenacity.

Early childhood special education programs are often non-traditional in nature. Administrators need to be open-minded and flexible in their approach to service delivery alternatives, staffing patterns and scheduling. In addition, early childhood programs, even more than programs for school-age children, require sensitivity to parents' needs. Effective programs directly involve parents in their child's program (Brofenbrenner, 1975). Thus, sensitivity to parents' individual differences is crucial if effective alternatives are to be developed and implemented in accordance with the needs of children and families.

Another important leadership characteristic is the administrator's willingness to work cooperatively with other agencies. In early childhood special education provision of a full-service program requires coordination of multiple community resources. An administrator whose vision is limited to only those services and funding sources available in the public schools will hinder efforts to develop a maximum service delivery system. A creative problem-solving approach is often required to determine how best to provide all the needed services to handicapped children and their families.

These characteristics:

-knowledgeable
-committed
-flexible
-sensitive
-creative

are important for any leader, but particularly important for administrators in early childhood special education.

LEADERSHIP FUNCTIONS

Marks (1971) identifies the primary purposes of leadership as:

1. facilitating the development of goals and policies which are basic to the services provided;
2. stimulating the development of appropriate programs;

3. procuring and supervising personnel so as to implement programs.

Decker and Decker (1976) identify a five step process in planning for a program:

"1) identifying legitimate goals for the local early childhood program; 2) communicating these goals to those who will help in the planning and administering of the program; 3) determining the process by which these goals will be met; 4) operationalizing the means for their achievement; and 5) providing feedback and evaluation" (p.7).

One of the first steps the coordinator of the program must take is the development of goals for the program. These goals may derive from a) professional and personal belief; b) funding sources; 3) the advisory board; and/or d) implications or stated desires of staff members and of families of children to be served in the program(Hewes, 1979).

Secondly, goals need to be communicated to those who will help in the planning and administering of the program. Goals should be discussed with upper level administrators, parents, staff and community agency representatives. The third step is determining the process by which the goals will be met. Objectives to be accomplished need to be delineated along with specific processes, procedures and activities which will be utilized to meet the objectives. The specifics of who will have what roles and responsibilities in relation to these activities along with time lines for accomplishment entails the fourth step - operationalizing their achievement. The last step, providing for feedback and evaluation include a) establishing mechanisms for on-going communication in relation to program objectives and processes; b) providing for communication channels between administrators, staff, parents and children; c) delineating formative (on-going) and summative (annual) evaluation procedures.

RESPONSIBILITIES OF THE ECSE COORDINATOR/DIRECTOR

The job description of the ECSE Coordinator/Director reflects the total planning, implementation and evaluation process. Let us first examine the responsibilities of the ECSE administrator and then delineate the processes and procedures inherent within these responsibilities.

Sciarra(1979) and the Council of Exceptional Children (1977) **identify** the following among the tasks of the program director:

1. Develop goals and objectives in relation to the program's philosophy, placing emphasis on needs of children.
2. Work with the staff to plan a curriculum to meet the objectives of the program.
3. Develop a positive working relationship with the administration, the school board, and the advisory board, placing emphasis on communicating accomplishments and needs.
4. Establish policies for program operation.
5. Draw up procedures for implementation of the policies.
6. Prepare and maintain a policy manual.
7. Comply with all local, state and federal laws relating to the program operation.
8. Establish and operate within a workable budget.
9. Develop job descriptions.
10. Recruit and employ qualified staff.
11. Prepare budget and control expenditures.
12. Help design and plan for the evaluation of the program, the staff members. and the children's progress.
13. Develop an effective communication system among staff members through regular staff meetings, conferences and informal conversations.

14. Coordinate and provide inservice training for professionals, paraprofessionals and volunteers.

15. Plan and implement a parent component that is responsive to parents' needs and interests.

16. Act as a liaison between the community, human service agencies, the school board, staff and families.

17. Develop a system for maintaining accurate financial records.

18. Design a transportation plan to supplement the existing school schedule.

PLANNING GOALS AND OBJECTIVES

An examination of the processes involved in the above responsibilities will provide guidelines for program planning. The following chapter on Conceptualizing and Developing a Program discusses all of the components which contribute to a program philosophy from which program goals and objectives derive. Goals may be determined for several broad areas:

-services to children
-services to families
-staff development
-coordination of community resources
-dissemination/demonstration

Goal statements should indicate the direction and intent of accomplishments for each area. For example: A goal for services to children (see chart p. 57) is "to identify and serve handicapped children from birth to six years old." Objectives under each goal should be specific and, as for children, measurable. Each objective should have implications for the evaluation procedures to be used to measure the extent of its attainment. The charts on pages 57 to 68 provide representative samples of goals, objectives and activities which might be planned by a program. Of course, every program is different and these goals, objectives and activities will change, depending on local needs.

Selection and development of curricula for the program should be done by the total staff. Curricular decisions need to reflect the program philosophy and the program objectives. Chapter 6 addresses issues related to curriculum and program decisions.

ESTABLISHING COMMUNICATION LINKS

The ECSE administrator is a key individual in promoting external (inter-program) communication. Externally, the ECSE administrator must relate to:

-building teachers and staff
-building administrators
-district administrators
-school board
-human service agencies
-the community

It is desirable for ECSE programs to be housed in regular elementary school buildings. If this is the case, the relationship with other teachers in the building and the principal is important from the standpoint of harmony. The presence of very young handicapped children with the concurrent noise and constant influx of parents may prove to be a discordant note to a traditional school setting. Establishing a level of understanding with all staff from the beginning is thus very important. An explanation of the rationale for early intervention and the justification for the program design is required prior to program implementation. Cooperation from regular classroom teachers will enable mainstreaming efforts to begin. The ECSE coordinator may need to provide in-service concerning the children to be served and the types of handicaps and special problems which those children have. Too often the early childhood program is just "that room" down the hall which is enshrouded in mystery and misconception. The level of understanding and support which is established at the beginning of the program may set the tone for the whole year.

Building principals are key figures for early intervention programs. The programs are housed in what they consider "their" buildings and therefore come under their responsibility. Depending on the lines of authority, the principal may be the direct supervisor of the ECSE coordinator or may have parallel responsibilities. In either case, it is important to obtain the principal's commitment to the early childhood special education program. Advocacy and support by the building principal will facilitate 1) more flexible staff usage; 2) non-early childhood staff cooperation; 3) materials and equipment exchange and 4) program continuation. Particularly, for the innovative programs in early childhood, it is important to have regular education and other advocates who are not directly involved in the program. These "non-biased", advocates can often be very persuasive in talking with school boards and other school administrators in obtaining continued program support.

There is also a need for direct communication with the upper level district administrators and the school board. Developing channels for input will again allow positive feelings toward the early childhood program to develop over time. Providing evaluation data on progress and growth will enable gradual establishment of support which will build the foundation for later continuation requests. If the communication lines are established early, the last minute rush of emotional appeals may be avoided.

The ECSE coordinator must also relate to human service agencies and the community at large. The number of agencies serving handicapped children and their families is impressive. If comprehensive services are to be provided, coordination of resources is essential. Chapter 4 provides detailed guidelines to assist in the development of interagency communication and cooperation. The ECSE coordinator should work on establishing these communication channels during the program planning phase. Then, as children enter the program alternatives will be available to meet their needs in the most effective and efficient way.

Communication with the community at large is also important. If early intervention programs are to become institutionalized, permanent components of our education system, it is imperative that the taxpayers understand why we need to serve handicapped infants and preschoolers. Their support is necessary for the establishment of a long-term commitment to early childhood special education. Therefore, the ECSE coordinator also needs to become a media specialist. Special events or feature stories can be covered in the local newspaper. Television spots or features on unusual or special situations are effective. Talking to community organizations and parent groups helps recruit others to work on the dissemination of the program concept. Pamphlets, newsletters, participation in community events - all contribute to visibility in the community. This type of visibility is important for on-going support of the early intervention programs.

Concurrent with the establishment of external communication links, internal communication channels must also be established. The ECSE coordinator can facilitate the development and maintenance of on-going staff discussion by ensuring the presence of mechanisms for feedback among

-staff

-staff and parents

-staff and administration

-staff and community.

One way to guarantee communication is to build it into the schedule. Often administrators expect staff to meet before or after school hours to discuss children, special topics, or have conferences with parents. This is, in effect, telling staff that such communication is an adjunct to their job, not a crucial part of the job. Perhaps one reason so many educators are "burning out" is that there is lack of support for carrying out many of the roles that are part of their jobs. Recognizing the critical nature of these responsibilities, they do these tasks in addition to everything else, but without the administrative support essential to carry them out most effectively. Team meetings, staff meetings, parent conferences, home visits, meetings with the coordinator and other communication processes are critical to effective program operation. They should, therefore, be allotted time in the scheduling and planning of the program design. The ECSE coordinator needs to include these responsibilities in job descriptions as well as provide time and support for staff to adequately perform these functions.

DEVELOPING POLICIES AND PROCEDURES

Policies are statements of written assurances of a course of action, while procedures provide specific guidelines for meeting the intent of the policy. Policies are typically made by the Board of Education, while procedures are developed by administrators in order to implement policy. Policies are developed for the following reasons:

1) to meet requirements of state agencies
2) to provide guidelines for achieving program goals
3) to assist in avoidance of inconsistency
4) as a basis for decision-making
5) to assure fairness and protection of program, staff, children and parents.

All school districts have extensive existing policies and procedures which guide administrative governance. Early childhood special education programs within the public schools must adhere to these policies and procedures, but may also want to establish additional policies which are unique to them as a result of their distinct population, range of services and mode of operation.

Decker and Decker (1976) describe categories for which policies in early childhood are appropriate. With adaptations these include:

1. Administrative policy including a) meeting legal requirements; b) the appointment and functions of the director and supervisory personnel; c) administrative operations.
2. Child-personnel policy a) referral and assessment and placement; b) attendance; c) continuum of program services; d) termination of program services; e) assessing and reporting children's progress; f) provisions for child welfare (accidents and insurance); g) special activities (e.g. field trips and class celebrations); and h) services to parents.
3. Staff-personnel policy a) recruitment, selection and appointment; b)qualifications; c) job assignment; d) evaluation; e) tenure; f) separation; g) salary schedules and fringe benefits; h) absences and leaves; and i) personal and **professional** activities.
4. Fiscal policy a) sources of funding; b) nature of budget (e.g. preparation, adoption and publication); c) categories of expenditures; d) guidelines and procedures for purchasing goods and services; e) system of accounts and auditing procedures, and f) accounting for per child expenditures.

5. Public relations policy a) types of participation by the public (e.g. citizen's advisory committees and volunteers); b) use of program facilities; c) relations with various agencies and associations; and d) media used for communication with public. (Decker and Decker, 1976, p 17).

ADMINISTRATIVE POLICY

Within the administrative policy area, policies should be developed by the district addressing each of the requirements of P.L. 94-142 and written assurances should be provided to the state regarding the provision of

-due process

-free appropriate public education

-individualized education plan

-a continuum of services

-placement in least restrictive environment.

The existing school policies may already address many of the other issues such as salary and tenure. The ECSE coordinator needs to be familiar with school policies and procedures in each of these areas and be able to assess where additional policies would be required. A policy and procedures handbook should be developed which delineates the principles under which the program operates. This handbook "exerts a stabilizing effect upon the organization, serves as a guide to performance and provides a standard against which to measure accomplishment" (Marks, 1971, p.92).

The time involved in developing such a manual and providing in-service to the staff on its content and use, will be rewarded by reduced conflict and misunderstandings. It will also serve as a common base for discussions of problems relating to specific policy areas.

A detailed discussion of each of the areas mentioned will not be attempted here. However, there are several policy areas which are particularly relevant to early childhood special education and the legal mandates of P. L. 94-142.

DUE PROCESS

As outlined in P. L. 94-142 each school district must meet minimum due process requirements in identification, evaluation and placement of handicapped children. The purpose of due process standards is to assure parent involvement in all decisions concerning their child's educational program and to protect the child's right to a free, appropriate public education.

Procedures should be developed to address the following requirements of due process:

1) Parents must be informed (in their native language) of all the rights that are provided them under the law.

2) Parents have the right to be notified whenever the school wishes to evaluate their child, wants to change an educational placement, or refuses their request for an evaluation or a change in placement.

3) The school must obtain written permission from parents before evaluating their child.

4) Parents have a right to request an independent evaluation if they disagree with the results of the school's evaluation. They also have a right to request a re-evaluation by the school if the parents question the appropriateness of the child's placement.

5) The child has a right to valid, comprehensive, non-biased testing by a multi-disciplinary team.

6) Parents have a right to review all of the child's educational records, to request removal of false or misleading information, and/or to place a statement in the child's records indicating the

portions with which they disagree.

7) Parents have the right to participate in developing their child's Individualized Education Program (IEP). They should be given every opportunity to be involved in the child's staffing. Written permission from parents must be obtained before the placement of the child.

8) Parents have the right to an impartial due process hearing if they disagree with decisions the school makes about their child's evaluation, placement, or services. They should be informed of their rights regarding a due process hearing.

Whenever possible, informal rather than formal processes should be utilized to resolve conflicts. Due process hearings tend to be adversarial in nature and thus result in negative feelings on the part of one side or the other after final decisions are made. Although rights are preserved, the resultant negative relations may not be constructive. Consequently, the school should develop procedures for informal discussion and mediation of differences which can be utilized prior to, and hopefully eliminate the need for, the due process hearing. These informal negotiations may not in any way impinge upon a parent's right to a written decision within 45 days of their request of a due process hearing.

9) A child has a right to a surrogate parent (guardian ad litem) when the child's parent or guardian is unknown, when the child's parents are unavailable, or when the child is a ward of the State.

CHILD-PERSONNEL POLICIES

Policies regarding how personnel will relate to children provide fundamental statements with regard to identification, referral, assessment and placement. Guarantee of rights and provisions for unbiased testing should be included. A description of continuum of services which will be provided, with provisions for how program modifications will be made should be designated. Specifics relating to classroom procedures and evaluation are also necessary. These issues are discussed more fully in ensuing chapters.

Three child-personnel policy concerns which need to be discussed in more detail relate to the development of policies regarding confidentiality, the distribution of medication, and the involvement of parents. These have particular relevance to handicapped children. If the school district does not have policy statements and procedures outlined for these concerns, the ECSE coordinator may need to work with the district in developing them.

CONFIDENTIALITY

A written policy regarding confidentiality is needed to guarantee the child's right to privacy. Procedures for retrieval and use of all information collected should be delineated as required by P.L. 93-380, Title V, Sec. 513,514. The Council for Exceptional Children (1977)has outlined four levels of information that may be accumulated pertinent to a child's participation in special education services.

Level I-Basic Identifying Data

-includes specific information regarding the child's name, address, academic achievement, attendance and health data.

Level II-Verified Data

-includes test results, medical history, classroom testing.

Level III-Tentative Data

-includes reports of professionals, reports from external agencies, anecdotal records.

Level IV-Professional files

-includes notes taken during interviews(may become Level III data if shared at staffings)

Each of these levels becomes increasingly more sensitive with regards to confidentiality. Levels I, II, and III are usually stored together in one place while Level IV data remains the professional's personal property. Level I data may be kept indefinitely, while Level II and III information must be destroyed or provided to parents within five years or after the information is no longer needed. This is to prevent stigmatizing information from following the child long after special services have ended. In early childhood special education this is particularly important, as early intervention may remediate or alleviate the specific problems to such a degree that regular class placement is possible sooner in the child's academic school years. It is important that when no longer needed, parents be notified and unnecessary and irrelevant information be deleted from the child's record. Procedures for periodic (annual) review of records should be established to ensure protection of the child's rights.

Policies and procedures should also be written with regard to the access of records:

- parental access to records
- the conditions of access to records
- student access to records (for later years)
- record keeping of who had access to the records and when

MEDICATION

Many young handicapped children need medications during the day. The program needs to establish a written policy and procedures for administering of medication. Although medical personnel are preferred for this responsibility, often programs do not have access to nursing or other medical personnel. Procedures should include:

-the personnel responsible for administering medication

-the conditions under which other persons may administer medication

-the methods by which medications will be locked and safely stored.

PARENT INVOLVEMENT

School districts cannot require parental involvement in school programs. However, the importance of parent-child interaction and follow-through in ECSE programs is so crucial to maximum program effectiveness that a policy statement in this area is recommended. The continuum of parent involvement alternatives should be addressed along with a statement regarding why these options are felt to be significant to the child's growth. Procedures for initiating, carrying, modifying, and terminating such involvement should be outlined. Often these specifics are not spelled out, and parents choose not to become involved because they are unfamiliar with these change mechanisms. The parent involvement component will be discussed further in Chapter 7.

STAFF-PERSONNEL POLICIES

The school district may have existing policies regarding many staff-personnel issues. Those do not need to be redone, as staff-personnel policies will apply to ECSE staff. However, the interdisciplinary or transdisciplinary nature of early intervention programs may necessitate policies which address the variations in staff roles and responsibilities. Statement of the philosophical intent of staffing patterns may clarify for other administrators, staff, and parents the reason for overlapping and cooperative duties. Procedures need to be outlined describing the team processes which will be utilized including team planning, programming and evaluation.

STAFF DEVELOPMENT

Policies regarding staff development may also need to be written. Early childhood special education is a relatively new field, and many professionals though trained to work with handicapped children may not have been trained to work with very young handicapped children. They may also not have had training in working with and understanding other disciplines. The ECSE administrator may want to design a continuum for on-going professional development from professional readings to in-service to external classes and degrees. (This is discussed further in Chapter 8). Procedures should be outlined delineating the administrative expectations and how a staff member may become involved in staff development alternatives. Procedures for dissemination of information derived from current educational research and procedures for adopting new educational practices and materials are also important.

STAFF EVALUATION

Staff members also need written guidelines concerning their evaluation Specific procedures on who will supervise, how supervision will take place, and how often it will take place are needed. Methods for the establishment of mutually agreed upon goals between staff and supervisor, review and appeal procedures are also important staff safeguards.

FISCAL MANAGEMENT POLICY

Policies need to be developed with regard to how decisions concerning expenditures are made. The "bottom line" in fiscal decision making is that financial resources should be allocated on the basis of individual child needs rather than through estimates of traditional service usage. Recording systems need to:

1) track the costs of early childhood special education programs
    a) the number of children receiving service
    b) expenditures for identification and placement
    c) cost of the early childhood programs
2) account for all federal, state and local monies expended for young handicapped children
3) identify and record the total cost of educating the child in order to determine excess costs.

A policy statement should be written to indicate that fiscal decisions are made based on the written I.E.P. These decisions are made taking into consideration

- long/short term financial investments
- least restrictive placement
- determination of need to purchase service
- utilization of other public or private agency funds.

The sources of funding in ECSE programs may be more diverse than in school age programs, coordinating, for example, funds from EPSDT and Child Find activities. The policies regarding cooperative fiscal arrangements should be stated, particularly with regards to those services for which schools have first dollar responsibilities.

Procedures for determining costs on the following should be included.

- salaries
- benefits
- supplies
- equipment
- facilities
- overhead
- food
- transportation

as well as determination of "in-kind", or donated goods and services.

Existing school policies and procedures must be utilized for accounting and auditing procedures, but specific care should be taken in determining per child expenditures. These figures may become very important in program continuation discussions.

PUBLIC RELATIONS POLICIES

The early childhood special education program should be represented on the school district's special education advisory panel. It is also recommended that a separate but cooperative advisory panel be formed for the ECSE program. Policies regarding this advisory board and procedures for selection and rotation of members need to be written. Suggested membership might include:

-parents

-staff

-regular education preschool or kindergarten teacher

-administrator of ECSE

-consumer representative of a local advocacy organization

-professional from higher education or someone involved in training who prepares persons for employment in ECSE

-administrator from the school district

Such an advisory board can provide a firm advocacy base and also serve as a link to the community. The policies regarding the advisory board need to take into account the duties of the members. As delineated by the Council for Exceptional Children, the following might comprise a few of the responsibilities:

-assist in developing plans for identifying children who need special services

-assist in the formulation and development of long-range plans for ECSE

-assist in the development of priorities and strategies for meeting the identified and special education and related service needs

-submit reports on committee's findings and recommendations for action

-assist in dissemination and interpretation to the school board and community of committee's recommendations and plans for implementation (policy number 1005 Council for Exceptional Children, 1977).

Policies with respect to interagency agreements and procedures to be followed in developing formal and informal agreements might also be considered to fall in the area of public realtions. (This will be discussed in Chapter 4 .) Also in this policy area would be policies regarding the use of media and parental permission for child involvement in such media coverage. Specific procedures for assuring a positive community and school district image need to be outlined.

If the ECSE program is going to involve non-handicapped children and/or work with non-handicapped preschool programs outside of the public schools, guidelines for establishing and evaluating such efforts are needed. Determination of the school policies relating to visiting groups (e.g. staffing patterns, insurance, etc.) should be coordinated with policies regarding mainstreaming. Planning for possible inconsistent policies may alleviate difficulties at later stages in the program.

The charts on pages 57 to 68 outline policies and procedures which need to be developed in relation to program goals, objectives and activities. These charts may be used as a reference during program development.

SUPERVISION RESPONSIBILITIES

In addition to program planning and the establishment of policies and procedures, the ECSE coordinator has a supervisory role which is critical and fundamental. The initial planning of the tasks that need to be accomplished must be matched with qualified persons who can best perform those tasks.

Therefore, one of the first steps the ECSE coordinator must do is develop job descriptions which delineate the duties that must be performed, descriptions of each responsibility and qualifications or competencies required to carry out the tasks. Figure 2 is an example of a job description developed for an early childhood special educator.

FIGURE 2. JOB DESCRIPTION *

Position: Speech/Language Therapist for an early intervention project for handicapped infants and toddlers and their families. Full Time.

Requirements:

Master's Degree in Speech Pathology.
Certificate of Clinical Competence in Speech Pathology, American Speech and Hearing Association.
Three years experience in speech/language fiels and one year experience with young children.

Responsibilities:

1. Provides comprehensive speech and language evaluations to all children referred to the project.
2. Contributes to the development of child's objectives in the language areas.
3. Plays active role in case reviews, parent conferences and IEP conferences. Plays role as case manager on a rotating basis with other team members.
4. Implements treatment services, conducts weekly individual therapy sessions and aids parents in home program facilitation.
5. Plans and implements weekly classroom plan on a rotating basis with other team members.
6. Participates in group parent sessions.
7. Participates in self evaluation process every six months.
8. Conducts evaluations of children every six months in appropriate areas.
9. Participates in staff development program and conducts some sessions.
10. Participates in dissemination activities, public awareness campaigns and the screening components as needed.
11. Provides general consultative services to the project in all areas of speech, language, hearing and general development of communication.

Salary: $15,000 per year, 40 hour week
Benefits: Three weeks annual vacation, health insurance and retirement benefits.

*Excerpted from "Stepping Stones - An Infant Toddler Early Intervention Program" by Kit Johnson, paper developed at the University of Denver, Denver, Colorado, 1980.

Once a staff has been selected and the program has begun operation the ECSE coordinator becomes a facilitator and catalyst for growth. Supervision usually has a threatening and negative connotation, but if the goals of supervision are developed, understood and shared with staff, the results can be quite positive. Marks, et al. (1971) includes in supervisory goals:

1. To help staff understand program goals.
2. To help staff see more clearly the needs of children and families.
3. To construct strong group morale and to unify staff into an effective team working to achieve program goals.
4. To encourage staff to develop their capabilities.
5. To assist in the development of greater competence.
6. To evaluate staff efforts in terms of growth toward predetermined goals.

In order to accomplish these goals a special type of administrator is desirable. Rogers (1961) describes an "administrator who is warmly emotional and expressive, respectful of the individuality of himself and of the other, and who exhibits a nonpossessive caring" (p.42). Other characteristics which lend themselves to effective administration include

-the ability to offer and accept new ideas

-sincerity in concern for others

-the ability to be supportive and reinforcing

-use of a democratic approach

It is important that staff have one person to whom they can turn to facilitate the accomplishment of their duties. Hart (1978) outlines specific facilitative responsibilities. The supervisor needs to:

1. Work with early childhood special educators to arrange the flow of information among the team members, the parents, and the teachers so that

everyone knows that objectives have been set and how they are being met.

2. Respond to parents and team needs for information, observation and testing.

3. Arrange for outside resources.

4. Provide feedback to staff.

5. Provide opportunities for continuous learning.

6. Analyze program implementation into manageable activities and tasks.

7. Organize weekly review sessions.

8. Develop standards for effectiveness.

9. Study the teaching - learning situation to ascertain how it can be improved.

As important as the coordinator/supervisor is, there are other relationships which are as important among the various staff members. Each staff member has a number of duties, the nature of which may be

-advisory

-consultative

-technical

-managerial

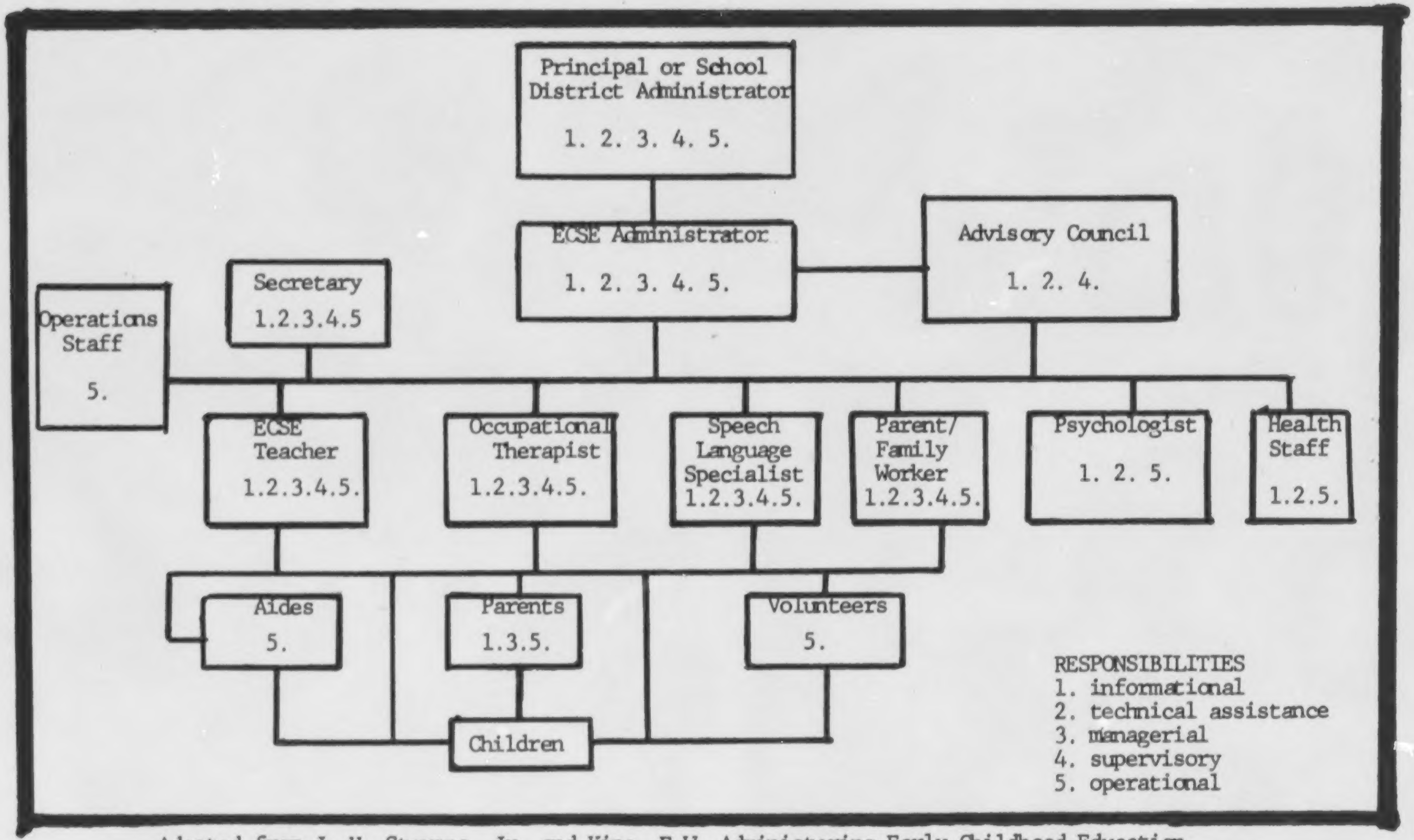
-supervisory

-operational (Marks, 1971, p. 99)

The development of a staff organization and responsibility chart helps staff and parents to perceive the intricate interrelationships among the staff and their responsibilities. Figure 3, pg. 55, is an example of a staff responsibility chart. An examination of the chart shows that there is an overlap in the nature of duties. An expanded chart might show the nature of information, technical assistance, etc. that each staff member shares.

FIGURE 3

STAFF ORGANIZATION AND RESPONSIBILITY CHART


Principal or School District Administrator
1. 2. 3. 4. 5.
ECSE Administrator
1. 2. 3. 4. 5.
Advisory Council
1. 2. 4.
Secretary
1.2.3.4.5
Operations Staff
5.
ECSE Teacher
1.2.3.4.5.
Occupational Therapist
1.2.3.4.5.
Speech Language Specialist
1.2.3.4.5.
Parent/ Family Worker
1.2.3.4.5.
Psychologist
1. 2. 5.
Health Staff
1.2.5.
Aides
5.
Parents
1.3.5.
Volunteers
5.
Children
RESPONSIBILITIES
1. informational
2. technical assistance
3. managerial
4. supervisory
5. operational

Adapted from J. H. Stevens, Jr. and King, E.W. Administering Early Childhood Education Programs, p. 279

Clearly, lines of communication and methods of communication are paramount if the children, who on the chart are connected to all team members, are to receive effective and efficient services.

SUMMARY

The coordinator of an early childhood special education program plays a crucial role in the program's success. The individual is not only a planner and interdisciplinary coordinator, he or she is also an advocate for children, families and staff; a program and fiscal manager; a stimulator; an adviser; a mediator; an interpretor; an evaluator and an educational prophet. The person to fill this role must be chosen wisely!

I. Services To Children

A. Child Find

Goal: To identify and serve handicapped children from birth to six years old

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
1. To implement semi-annual screening in three locations, screening at least 60% of the estimated population from birth to six.	1.1. Contact a minimum of 15 agencies in the school district and coordinate a meeting to discuss screening. 1.2. Coordinate screening efforts with other agencies including social services, health, institutions. 1.3. Conduct a community awareness campaign to include- -presentations to 10 service clubs and organizations -5 articles in local newspapers -10 air spots on local radio stations -distribution of 1000 fliers through grocery stores, food stamp stations, doctors' offices, schools. 1.4. Conduct developmental screenings at three different locations in the school district twice a year in cooperation with other community services and agencies. 1.5. Refer children with significant delays in one or more developmental areas for further evaluation.	Write a policy statement to indicate child find compliance with P.L. 94-142. Document step by step procedures for identification screening, and referral.

I. Services To Children

B. Assessment

Goal: To identify and serve handicapped children from birth to six

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
2. Within 60 days of referral 100% of children will be assessed, determination of handicapping condition will be made, service provisions will be planned, and I.E.P.'s written.	2.1. Due process procedures will be established and written documents for informing parents of due process rights will be developed.	Write a policy statement regarding assessment. Procedures include -due process procedures -non-disciminatory testing -placement in least restrictive environment -free appropriate education -individualized educational plan -annaul review of I.E.P. and placement.
	2.2. Guidelines for assessment and staffing will be developed.	
	2.3. In-service training concerning due process, assessment, I.E.P.'s, staffing procedures, and parent counseling will be conducted.	
	2.4. All children referred for assessment will receive appropriate evaluation, and case review. Children will be referred to appropriate placements if a handicap is determined to exist.	Exact procedures for -pre-assessment planning -assessment -staffing -classroom follow-up -evaluation should be delineated.
	2.5. Classroom assessments will be conducted to determine exact program needs, style of learning, and appropriate intervention techniques.	Fiscal policy should be written to reflect money allocation on a service needs basis.

I. Services To Children

C. Program

Goal: To identify and service handicapped children from birth to six

OBJECTIVE	ACTIVITIES	POLICIES AND PROCEDURES
3. Within 30 days of assessment 100% of children will be receiving appropriate services.	3.1. A full continuum of service alternatives will be developed to meet the needs of handicapped children and their families.	Policy regarding a continuum of services and non-categorical placement.
	3.2. Staff will be hired with competencies needed to provide a full range of services.	Staff personnel policies are needed. Procedures for -hiring -job descriptions -salary determination -termination
4. 90% of all handicapped children served will demonstrate continuous growth, as demonstrated through on-going evaluation.	4.1. Maximally effective learning environments will be developed to meet individual needs of children.	
	4.2. A variety of curricula will be selected to be used in program planning.	Policy regarding program and staff evaluation.
	4.3. A transdisciplinary team will meet at least weekly to plan child activities, evaluate progress, and modify program intervention strategies to assure continued growth.	Procedures for: -evaluating children -evaluating environments -evaluating staff -evaluating curricula and material -team coordination planning and evaluation.

I. Services To Children

C. Program

Goal: To identify and serve handicapped children from birth to six

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
	4.4. In-service training and professional development activities will be on-going based on needs assessed by the ECSE coordinator to increase staff knowledge and skills.	Fiscal policy regarding expenditure of funds is needed. Procedures for processing equipment and materials -determining per child expenditures
	4.5. Involve parents in a range of activities to ensure follow through at home.	Policy regarding staff development.
	4.6. Develop methods for integrating handicapped with non-handicapped children.	Procedures for: -assessing needs -alternative methods for professional growth -evaluation
	4.7. Develop a system for transition between services on the continuum with follow-up for the child and family.	Policy regarding mainstreaming Procedures for: -integration with non-public school programs

II. Services To Parents

A. Due Process

Goal: To provide parents with needed services

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
5.0 100% of parents of handicapped children will receive notification of their due process rights and have these rights explained.	5.1. All parents will receive due process information and have it explained by a staff member.	Policy regarding due process Procedures for due process developed -notification -explanation
	5.2. Parents will be encouraged to contribute in staffings and in the development of the I.E.P.	
	5.3. Parents will receive on-going notification of their child's progress and methods of measuring progress.	

II. Services To Parents

B. Parent Support

Goal: To provide parents with needed services

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
6.0. 75% of parents of children in the early intervention program will indicate that support services have helped them to cope with having a handicapped child.	6.1. Counseling services will be made available to the parents through the parent/family worker at staffings and regularly during the year.	Policy regarding support services to parents Procedures -for getting services -for evaluating services
	6.2. Parent support groups will be formed and made available to parents.	
	6.3. Parents will be notified of the Colorado Parents Encouraging Parents (PEP) program.	
	6.4. A method for pairing parents with each other will be devised to provide parent-to-parent support.	
	6.5. Materials will be made available to parents concerning -books, journals, etc. -parent organizations -advocacy groups	

II. Services to Parents

C. Parent Involvement

Goal: To provide parents with needed services

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
7.0. 80% of parents will participate in various activities offered by the early intervention program.	7.1. Develop alternative parent involvement activities, including -classroom participation -advisory board participation -program participation with children.	Policy regarding parent involvement and its importance to child growth. Procedures regarding due process rights.
	7.2. Develop means by which parents can participate in decision-making regarding their child's program. -staffings/I.E.P.'s -conferences -program modifications -child/program evaluation	
	7.3. Develop evaluation measures	
D. Parent Education		
8.0. 80% of parents will demonstrate increased knowledge regarding issues related to their handicapped child.	8.1. Develop program options for individualized parent education -classes -demonstration workshops -parent library -toy library -video tapes -counseling sessions -home demonstration -parent pairing -manuals	

II. Services To Parents

D. Parent Education (continued)

Goal: To provide parents with needed services

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
9.0. 80% of parents will demonstrate increased skill in interacting with their handicapped child.	9.1. Develop means of getting input from parents regarding their concerns about parent-child interactions.	
	9.2. Develop means of helping parents develop interaction skills which take into consideration their child's strengths and weaknesses. -direct teaching -modeling -demonstration -observation -reinforcement	
	9.3. Develop evaluation measures	

III. Staff Development

A. Pre-service/In-service

Goal: To increase staff skills in working with handicapped children

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
10.0 100% of staff hired will have appropriate credentials and will demonstrate competence in their work	10.1. Write job descriptions which indicate needed qualifications, background and experience, Delineate job responsibilities and philosophy of the program.	Staff/personnel policies
	10.2. Develop methods for interviewing to involve all team members and parents.	Procedures for hiring
11.0. 100% of staff will acquire a minimum of two needed skills and put them into use with children and families.	11.1. Develop means by which to ascertain staff needs for staff development activities -pre-tests -questionnaires -observation -interviews	Policy regarding in-service education
	11.2. Establish systematic methods for in-service education -classes -workshops -journals -consultation -materials center -demonstration teaching -instructional guides -institutes -intervisitations	
	11.3. Develop evaluation measures	

III. Staff Development

B. Staff Evaluation

Goal: To increase staff skills in working with handicapped children

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
12.0. 100 % of staff will be effectively evaluated on a regular basis.	12.1. Develop staff utilization and evaluation measures -peer ratings -interviews -observation scales -forms .time/scheduling .staff/child ratios .meetings .planning times 12.2. Develop means for determining the effectiveness of staff evaluation procedures.	Staff evaluation procedures should be clearly delineated.

IV. Coordination of Resources

Goal: To increase services to handicapped children

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
13.0. Services to children will be provided in the most effective and efficient method 75% of the time.	13.1. Develop a system for coordination of services and funding among community agencies to include -initial contacts -planning meetings -on-going interaction around specific children -evaluation efforts	Procedures for development of interagency agreements

V. Demonstration/Dissemination

Goal: To increase awareness of effective programs

OBJECTIVES	ACTIVITIES	POLICIES AND PROCEDURES
14.0 Information concerning effective intervention practices will be demonstrated or disseminated to ten other programs in the city or state.	14.1. A plan for demonstration and dissemination will be developed to include -timeliness -projected presentations -projected products -evaluation measures	

*Demonstration/dissemination objectives and activities may not be needed in non-grant funded projects

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THREE

CONCEPTUALIZING AND DEVELOPING A PROGRAM

IMPORTANCE OF PHILOSOPHY

Webster's Dictionary (1967) defines philosophy as "an analysis of the grounds of and concepts expressing fundamental beliefs" and also "a theory underlying or regarding a sphere of activity or thought". In order to adequately serve handicapped children and their families we need to examine our "fundamental beliefs" about how children learn and our theories concerning how best we can facilitate their optimal growth and development.

Service delivery models which have been developed in the past have had their roots in a particular philosophy or theoretical model. Many of the philosophies stem from beliefs regarding the etiology of handicapping conditions. Some stem from particular learning or developmental theories.

The perception of the how the environment contributes to learning is an element of the philosophy. The roles and responsibilities of the various staff members, the teacher and the parents within the program is also a reflection of "fundamental beliefs" about education and learning. One final element which contributes to the program philosophy is the content or targets chosen to be part of the curriculum. These considerations:

-etiology of handicap
-learning/developmental theories
-role of environment
-role of staff
-role of parents
-program content/targets of training

are important elements to be carefully examined in developing a philosophy and consequently designing a program model.

A model which is chosen to be implemented in an infant or preschool program should reflect the philosophy of the agency and its staff and consumers. Program policies, procedures, and staffing patterns should reflect the philosophy. Program goals, objectives, activities and evaluation methods should also indicate this underlying philosophy.

ADVANTAGES OF PHILOSOPHICAL UNITY

The advantages of an agreed upon philosophical orientation are numerous. Staff may perceive their commonly held values as a unifying element, a foundation from which to begin program development, a check-point for formative discussions of program implementation and modification, and a basis for determination of summative evaluation concerns. Staff who understand and operate from a common theoretical and philosophical base, will utilize consistent terminology and "jargon", thus facilitating staff communication. A unified philosophy also reduces the possibility of conflict around selection of assessment instruments, curricula, and strategies and techniques of intervention.

PROCESS MODEL FOR DETERMINATION OF SERVICE DELIVERY SYSTEM

Determination of the nature of the philosophy and the service delivery system is not as easy as might be imagined.

Often projects choose an assessment instrument, curriculum or program model without considering all the relevant factors. Perhaps the instrument or curriculum is the most widely used, the staff have attended a workshop on it, or it has been endorsed by a respected professional. These should not be the most important considerations in choosing or designing any of the program components.

The nature of the population, the services which are needed, the overall program philosophy, including model, curriculum, staffing patterns and site of services all impact on the nature of the interactions between staff-child-parent-environment. Each of these factors contributes to the final decisions about program design. Figure 1 outlines a process model which can facilitate decision-making. Each of the components will be discussed to illustrate its effect on program planning.

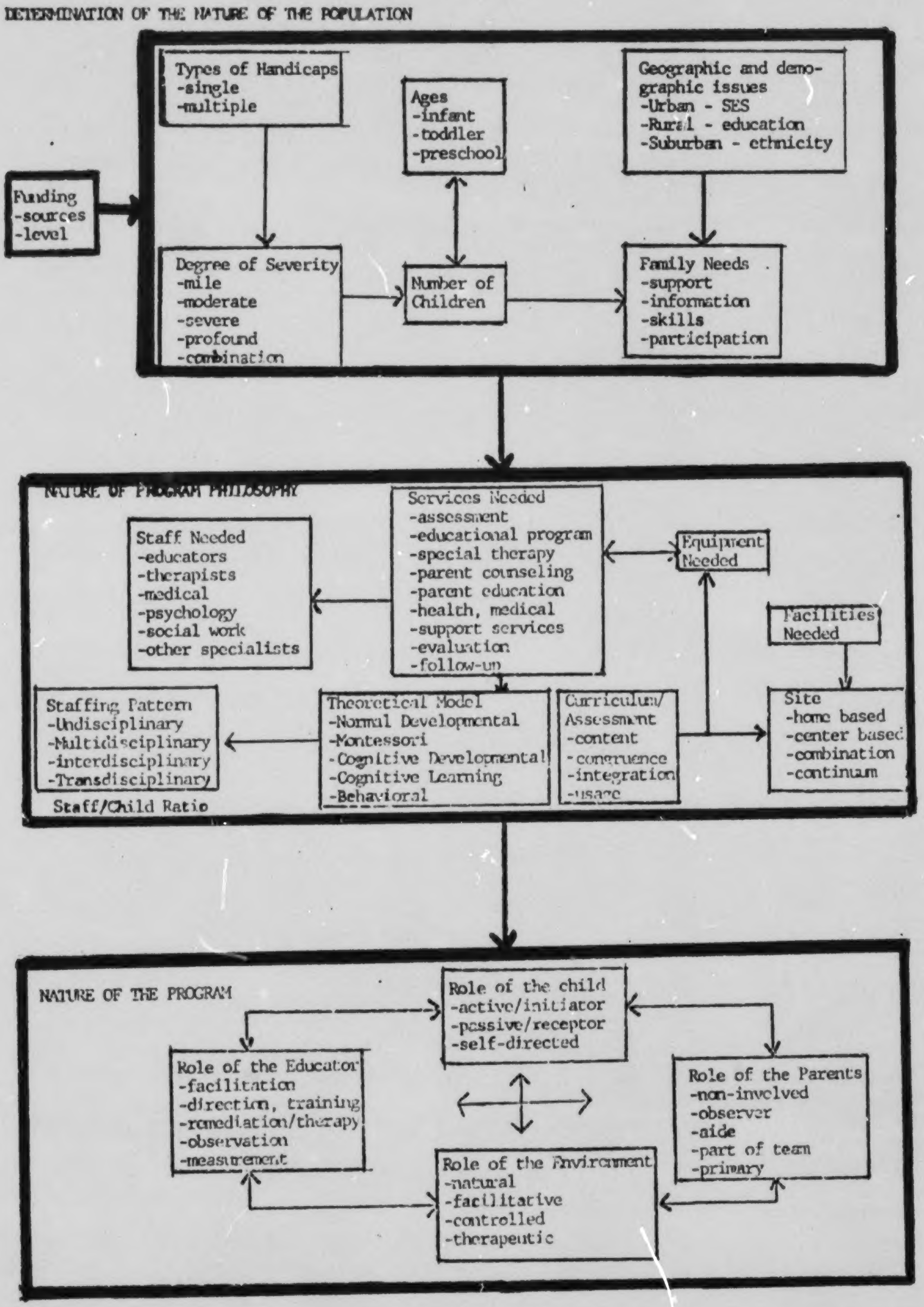
HANDICAPPING CONDITIONS

Types of Handicaps

-single
-multiple

When examining the information on the population to be served, staff need to determine the types and range of handicapping conditions identified. What handicaps are to be served? Is the population relatively homogeneous? (i.e., by handicapping condition, language impaired, blind, deaf or by age, functioning level, etc.). If a single type of handicap is being served it has implications for the type of services, staff and curriculum needed. For example, if blind preschool children are to be served, qualified vision specialists, or teachers trained as educators of the blind will be needed. Mobility training may become part of the curriculum. Special materials or equipment, such as "twin vision" books and multi-sensory toys may be necessary. If a hetergeneous group is being served, children with different handicaps, other considerations are important. For example if children with cerebral palsy, mental retardation,

Figure 1. Developing a Philosophy for Early Intervention


DETERMINATION OF THE NATURE OF THE POPULATION
Funding
-sources
-level
Types of Handicaps
-single
-multiple
Ages
-infant
-toddler
-preschool
Geographic and demographic issues
-Urban - SES
-Rural - education
-Suburban - ethnicity
Degree of Severity
-mile
-moderate
-severe
-profound
-combination
Number of Children
Family Needs
-support
-information
-skills
-participation
NATURE OF PROGRAM PHILOSOPHY
Staff Needed
-educators
-therapists
-medical
-psychology
-social work
-other specialists
Services Needed
-assessment
-educational program
-special therapy
-parent counseling
-parent education
-health, medical
-support services
-evaluation
-follow-up
Equipment Needed
Facilities Needed
Staffing Pattern
-Undisciplinary
-Multidisciplinary
-interdisciplinary
-Transdisciplinary
Staff/Child Ratio
Theoretical Model
-Normal Developmental
-Montessori
-Cognitive Developmental
-Cognitive Learning
-Behavioral
Curriculum/Assessment
-content
-congruence
-integration
-usage
Site
-home based
-center based
-combination
-continuum
NATURE OF THE PROGRAM
Role of the child
-active/initiator
-passive/receptor
-self-directed
Role of the Educator
-facilitation
-direction, training
-remediation/therapy
-observation
-measurement
Role of the Parents
-non-involved
-observer
-aide
-part of team
-primary
Role of the Environment
-natural
-facilitative
-controlled
-therapeutic

emotional disturbance are all to be served, the staff, staffing patterns, in service, curricula, the schedule, the philosophical model are all influenced. A physical therapist may be needed by the cerebral palsied and mentally retarded child. The teacher may need skills and understanding of positioning techniques as well as skills in behavior management and specific skills in the development of language and cognition. Some children may be able to actively explore their environment, while others may need facilitation, or direct guidance. A curriculum emphasizing social and emotional development may be more appropriate for the emotionally disturbed child.

If a non-categorical approach is used to identify children, so as to reduce the negative effects of labeling, children's needs rather than "handicapping conditions" will be identified. Program design will be influenced in the same manner.

The number of handicapped children with specific handicaps or needs is also important, as it will influence the number of staff needed and perhaps the service delivery mode, i.e. a home based program may be appropriate for a multiply handicapped child who is unable to maximally benefit from a center-based program which is based on a cognitively-oriented curriculum and serves predominantly mildly handicapped children.

DEGREE OF SEVERITY

-mild
-moderate
-severe
-profound
-combination

The degree of severity of a handicapping condition has an effect on needed services, both for the child and the family. A child who is profoundly retarded and physically handicapped, may place great stress on the family. The family may need support to be able to maintain the child at home. They may need to develop special skills to be able to work with the child, and they may need an understanding of the strengths and interaction patterns of the child to enable them to be able to interact positively with the child. The child may need specialized therapy and a highly structured environment to foster learning. A home-based program may meet some family needs, however, a center-based setting might allow some relief to the family and enable the child to receive input from multiple therapists.

AGES

- -infant
- -toddler
- -preschool

The age range of the children to be served is also important. Although any age child may be served in any of the optional settings, models, staffing patterns, etc., when combined with type of handicap and degree of severity, the age factor can become a critical factor. For instance, if twelve moderately retarded four year olds were in need of service, a center-based program (regardless of the model) would enable the children to gain important social interactions. Age can also have an impact on the amount of time a child can attend to the activities presented. The attention span of an infant, for instance, may preclude lengthy 2½ hour programs.

FAMILY NEEDS

- -support
- -information
- -skills
- -participation

In assessing the needs of children, the needs of families should also be evaluated. The success of the program in effectuating positive growth in the child, may depend on the success of the program in serving the family (Bronfenbrenner, 1975). Parents who have their emotional and survival needs met, have more energy to expend on behalf of their handicapped child. Lillie and Trohanis (1976) discuss parents needs in the areas of emotional support, exchange of information, facilitation of positive parent-child interactions and participation in the program. Depending on the identified needs and interests of the parents, the child's program may vary. For example, parents who are deeply grieving the birth of the handicapped child may be emotionally unavailable to address the child's needs. They may be unable to follow through on implementation of a home-based program. By involving the child in a center-based program while the parents are involved in support groups, counseling or educational activities, the parents may be able to work through their feelings, acquire new understanding of the strengths and limitations of the child, and gain new skills for coping with the problems inherent in raising a handicapped child.

GEOGRAPHIC AND DEMOGRAPHIC ISSUES

-Urban	-SES
-Rural	-Education
-Suburban	-Ethnicity

The geographic size of the area served as well as the demographics of the population are concerns which impact on families' needs. If the area served is rural and covers many square miles or is small but mountainous or rugged terrain, transportation may be a problem. Parents may have difficulty consistently making it to a center-based program. If busses are involved, the number of hours children must spend on a bus (especially if they are young children) may make center-based programs impractical. There is not much value in providing a two-hour stimulating, therapeutic, educational program to an exhausted, cranky two year old who has just spent 2½ hours going home. And think of the parents who "collect" the child at the end of the trip.

Demographics such as socio-economic status, education and ethnic background may have important implications for the child's program and the families needs. Parents of low socio-economic status may need considerable energy to get their daily survival needs met. Heating bills, court suits, unemployment may be pressing issues. What kind of toys the child has or how the child is positioned may seem frivolous and unimportant.

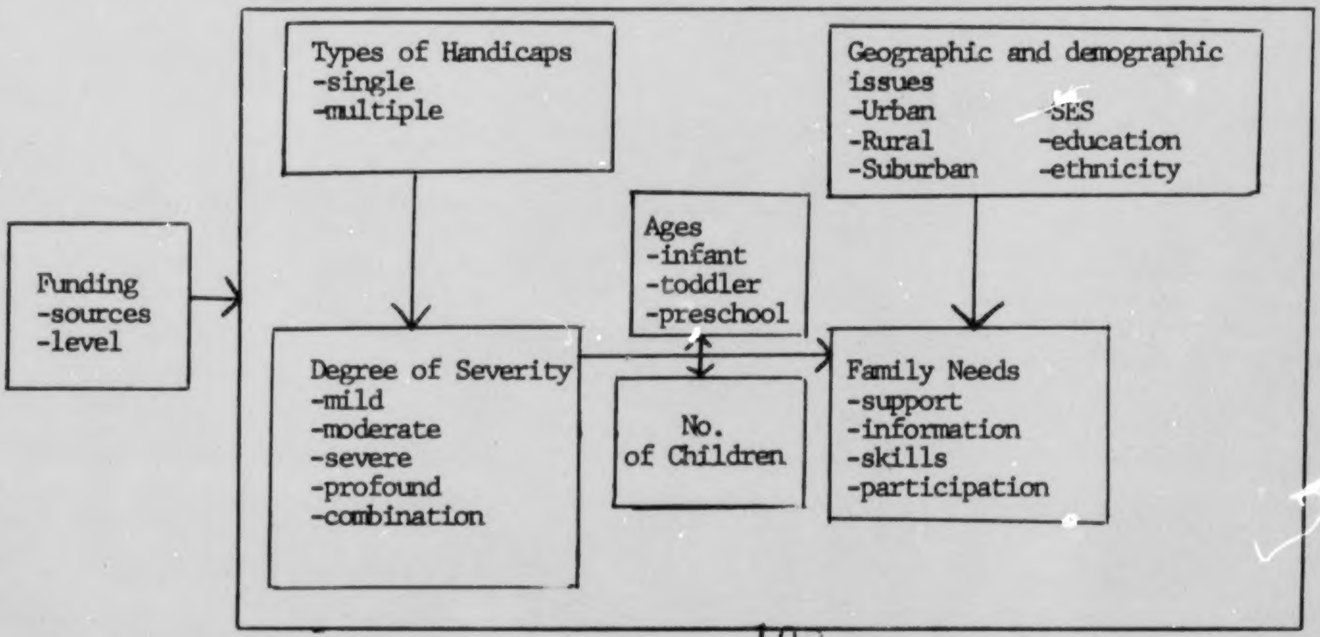
Parents of low socio-economic-status (SES) may also relate better to trained lay persons or paraprofessionals from their own neighborhood, whether it be urban or rural (Heber et.al. 1975; Shearer & Shearer, 1972). Until basic needs are met, educational goals are understandably post-poned or ignored.

The parents educational level also is important. If a parent can't read, it is inappropriate and often insulting to send home written program plans for the parent to follow. Books, pamphlets, letters will go unheeded. Alternate means of communication are necessary. On the other hand, many parents are eager to learn about everything concerning their child and the child's handicap. They will devour any and all information made available to them. They want and need to know and the program can be their most valuable information resource.

Ethnic differences also have implications for staff hiring and service delivery modes. Minority and/or bilingual personnel may be necessary if a significant percentage of the target population are minority or English is not the primary language. Cultural considerations may make home visits undesirable or parent involvement in school-based programs unrealistic.

Such geographic and demographic issues relate directly to the family's needs and thus to the child's needs. The development of the delivery system should involve analysis of families' needs, with alternatives for meeting these needs being reflected in the services which are available (See figure 2).

Figure 2. Determination of the Nature of the Population


Types of Handicaps
-single
-multiple
Geographic and demographic issues
-Urban
-Rural
-Suburban
-SES
-education
-ethnicity
Ages
-infant
-toddler
-preschool
Funding
-sources
-level
Degree of Severity
-mild
-moderate
-severe
-profound
-combination
No. of Children
Family Needs
-support
-information
-skills
-participation

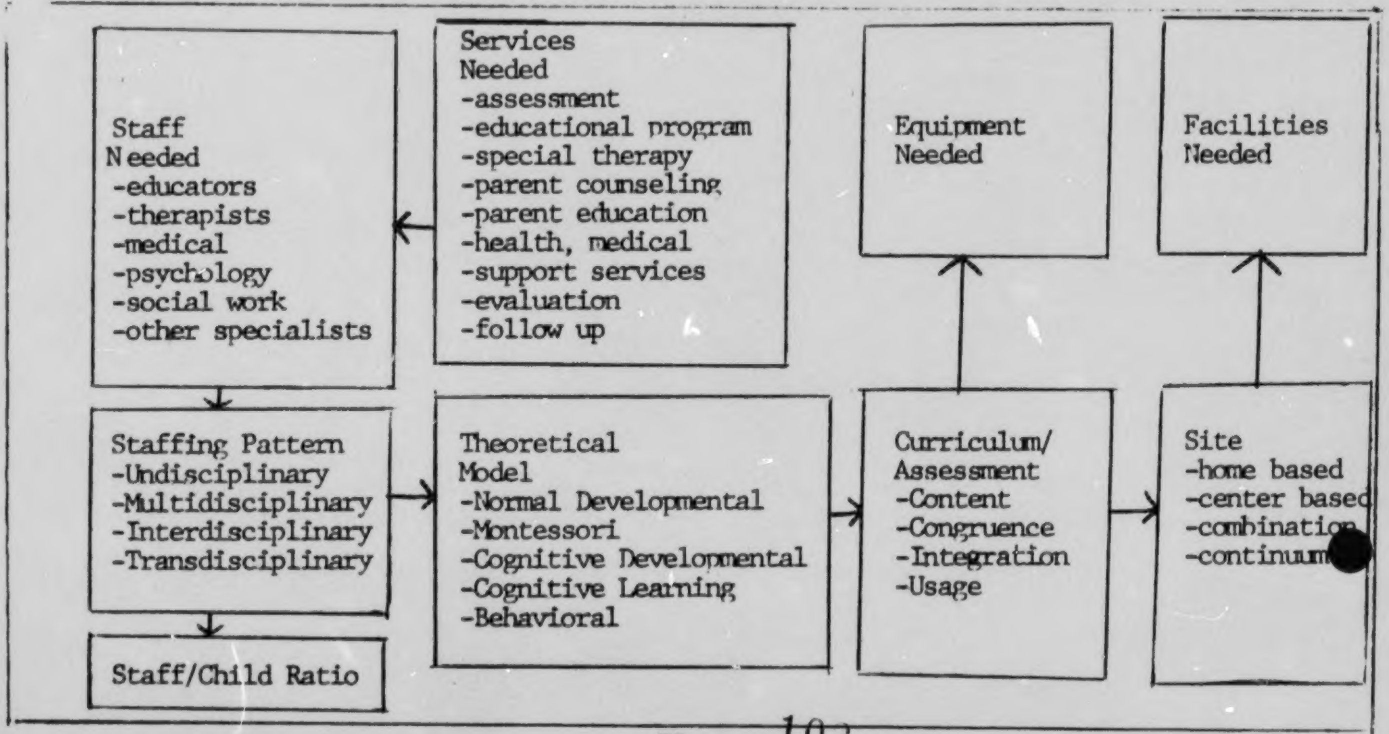
DETERMINATION OF THE PROGRAM PHILOSOPHY

Once the nature of the population has been determined, it is possible to ascertain the services which will be needed. Some of the types of services which may be implied include -

-assessment
-educational programming for the children
-specialized therapy (speech therapy, occupational therapy, physical therapy, etc.,)
-program planning for the parents (including counseling, education, training, and program participation alternatives)
-health, nutrition, medical consultation
-family support systems (including interagency services)
-ongoing evaluation
-follow-up consultation

The determination of the specific alternatives for how services will be delivered in each of these areas depends largely on the philosophical basis operating in each of four components: 1) staffing pattern, 2) theoretical program model, 3) curriculum and evaluation instruments, and 4) the site of service delivery. Each of these components should be in philosophical accord to assure program consistency and evaluation validity (See Figure 3).

Figure 3. Nature of Program Philosophy


Staff
Needed
-educators
-therapists
-medical
-psychology
-social work
-other specialists
Services
Needed
-assessment
-educational program
-special therapy
-parent counseling
-parent education
-health, medical
-support services
-evaluation
-follow up
Equipment
Needed
Facilities
Needed
Staffing Pattern
-Undisciplinary
-Multidisciplinary
-Interdisciplinary
-Transdisciplinary
Staff/Child Ratio
Theoretical
Model
-Normal Developmental
-Montessori
-Cognitive Developmental
-Cognitive Learning
-Behavioral
Curriculum/
Assessment
-Content
-Congruence
-Integration
-Usage
Site
-home based
-center base
-combinatio
-continuum

STAFFING PATTERN

- -Undisciplinary
- -Multidisciplinary
- -Interdisciplinary
- -Transdisciplinary

The determination of the services which will be needed leads to the next step - deciding who will provide these services. If moderately language delayed or speech impaired children are being served, the children will probably need both language experiences and training from an educator with expertise in facilitating and developing language skills in conjunction with other areas of development. A speech and language therapist may also be needed to do in-depth evaluations, provide individual and group therapy and to consult with the educator and/or parents on specific methods or techniques of training. Severely multiply handicapped children will need specialized assessments and interventions in all developmental areas, and thus occupational and/or physical therapists, speech and language therapists, vision specialists, medical consultation, social workers and other specialists may be needed depending on the individual child and family's needs.

As critical as the question of who is going to provide service, is the question of how these staff are going to provide service. One of the major difficulties encountered by new programs is the failure to carefully delineate roles and responsibilities of staff members - both individually and as a team (McNulty, 1980). It is of fundamental importance that staff members agree philosophically on the staffing pattern which will be most efficient and effective in serving the handicapped children and their families. Failure to do so can lead to duplication or gaps in services, misunderstandings and communication break down, and staff tension and dissention. A discussion of the various types of staffing patterns will serve to illustrate the philosophical implications of each.

UNIDISCIPLINARY APPROACH

Agencies which provide categorical services such as speech and language centers or mental health clinics may specialize in the disabilities they serve and in the type of treatment offered. A child who goes for therapy to the physical therapy department of the local hospital, will receive treatment from physical therapists who are primarily concerned with improving skills which relate to improving motor coordination. They may have suggestions on improvement of speech or feeding skills as they relate to the oral motor mechanisms, but speech and language therapists will not be part of their team. Such a unidisciplinary approach is appropriate for highly specific problems, but the child's and family's total needs will probably not be met with unilateral service.

Some day care and nursery school programs operate on a unidisciplinary staffing pattern primarily due to funding limitations. The discipline most frequently represented is an early childhood educator. Staff usually have background in normal development and normal developmental teaching models. Consequently they may have difficulty modifying the regular curriculum or standard teaching techniques to meet the needs of children who have deviant developmental patterns.

A unidisciplinary approach places a tremendous burden on staff who work with handicapped children. They need knowledge and expertise in all areas of child development, an understanding of delays and deviations, ability to remediate and facilitate growth and change in important skill areas. In addition, they need to be able to work closely with families on a variety of levels. Clearly it would be difficult to provide a comprehensive program with a unidisciplinary approach.

MULTIDISCIPLINARY TEAM

The multidisciplinary approach is frequently found in public school programs. Several disciplines are available to provide services to children and their families. These may most commonly include: psychologist, social worker, school nurse, speech and language pathologist, occupational therapist, and a special educator. The team usually functions in one of two ways. The usual pattern is that the various specialists see the child for the initial assessment and determination of appropriate placement. Specialists such as the speech and language therapist or the occupational therapist see specific children on a "pull-out" basis; that is they remove the child from the classroom, implement the child's therapy program, and take the child back to his classroom. Pull-out time becomes "magic" (Cessna, 1980) time, as no one else knows what methods or techniques are used to remediate the child's problem. What is worse, the techniques used by the various disciplines may actually be in conflict. The teacher conducts her educational program without much input from the therapists. The team meets to review IEP's and establish new goals and objectives. The social worker may be involved if a family is having problems with the child, or if the school is having "problems" with the family. This particular staffing pattern clearly differentiates between the expertise of the various disciplines.

A second similar multidisciplinary pattern is that all disciplines are involved to a varying degree with each child. They may work side by side, but their areas of responsibility are clearly defined (Holm and McCartin, 1978). For example, an infant program may have "centers" established for speech and language, gross motor, fine motor, cognitive and social emotional activities. Each of these areas may be supervised by a professional from a different discipline. Children are rotated through each center, thus receiving input from each expert on each area of development. The social worker may meet with a mothers' group, or individual mothers during this time. The team may meet on a regular basis to discuss their goals and objectives for each child. Limited consultation among team members may occur.

The limitation of a multidisciplinary team approach is that "this mode of sharing ... does not take full advantage of the range of skills each person brings to the team" (Holm and McCartin, 1978, p. 102). The child is treated in "pieces" rather than holistically.

INTERDISCIPLINARY TEAM

The interdisciplinary team focuses on interaction among a variety of disciplines. Consultation takes place among the personnel from the various disciplines so as to share information that could be important to the others on the team. For example, the occupational therapist who has been working on oral motor control may come into the classroom during snack time and work on feeding with the child while at the same time demonstrating and explaining to the teacher what techniques are being used with a rationale for each. The teacher can then utilize these techniques when the therapist is not present. The child still receives therapy from the specialist, but the generalization and practice of skills by the child is extended as a result of the team communication. Team meetings are held frequently to discuss both children's progress and effective methodology. Holm and McCartin (1978) describe interdisciplinary teams as able to "rely on each other to build on and complement the skills and expertise of the whole team" (p. 103).

One limitation of the multidisciplinary approach is that the quality and quanitity of team interaction may be limited due to heavy case loads. Time for cross-sharing may be limited unless it is specifically and frequently structured. Individuals tend to be more protective of professional "turf".

TRANSDISCIPLINARY TEAM

The difference between the interdisciplinary and transdisciplinary team is primarily a difference in degree. The transdisciplinary team actually educates each other and practices the skills of the various disciplines. Holm and McCartin in their discussion of this team approach say it "connotes crossing of discipline borders, assimilation of knowledge from other professions, and the incorporation of skills developed in other fields into one's practice" (p. 103). The home-based program often has a single staff member visiting the home. It would be cost-prohibitive to have the entire team visit each child in the program. Thus the home visitor needs to have skills from all of the other disciplines. The transdisciplinary team would through in-service, on-going consultation, and team planning meetings, assist each other in acquiring necessary intervention skills. For instance, the physical or occupational therapist would educate the other team members around such techniques as facilitation and inhibition, the special educator might demonstrate and explain cognitive sequences and facilitation of play behaviors, and the speech and language therapist might discuss approximations or parallel talking. During team meetings objectives and activities are discussed and continued information exchange takes place across disciplines. The teacher is not expected to become a physical therapist or speech and language pathologist, or vice versa. The continued exchange and support of the team is a vital aspect of the transdisciplinary team concept. The advantage of this approach, is that each team member works with the whole child, rather than a specific aspect of the handicapping condition. There is a disadvantage if the child does not receive needed individual therapy from a specialist. Optimally the transdisciplinary approach should combine individual therapy (when appropriate) with generalization of that therapy through the other disciplines. Rather than always providing direct therapy to each child, the therapist must adopt the role of resource person using the classroom staff and parents as the primary implementers of the rehabilitative staff (Sternat, Messina, Neitupski, Lyon, and Brown, 1977). Iacino and Bricker (in press) describe the ideal interventionist as a "generative teacher" who must have skill as a synthesizer. "The interactive effects of a child's physical and mental health, his nutrition, and his social environment on his developmental progress make it imperative that the teacher be willing to and capable of actively seeking, evaluating, and implementing information from a wide range of professionals."

The problems of young handicapped children are multifaceted. Many times one approach or the expertise from a single discipline is not adequate to deal with the child's and family's needs. A coordinated, multi-dimensional approach is most effective. Children are complex organisms, and the deviations or delays in any one area of development impact greatly on the others. Any program philosophy should take into consideration how its staff can most successfully deal with the totality of needs with a minimum of duplication fragmentation or contradiction of services.

It should also be remembered that staffing patterns influence the staff/child ratio. The number of children each staff member works with should not be the only criterion for determining the type and amount of services received by children and families. The actual number of contact hours spent with individual children, groups of children, in consultation and in team meeting are all important considerations. It is important for administrators to recognize that the transdisciplinary communication concerning specific children which takes place in team meetings is time spent serving the child and family. Administrative support of team meetings is essential for maximum service delivery.

THEORETICAL MODELS

-Normal Developmental
-Montessori
-Cognitive Developmental
-Cognitive Learning
-Behavioral

How do children learn? What is the relationship between genetic, maturational and environmental factors? How best can developmental growth and learning be facilitated in the handicapped child? What is the role of the child in his own learning? What are the roles of the teacher, the therapist, the parents? Depending on what answers are accepted, one arrives at a different theoretical model

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for education.

Throughout the course of history theories of how learning takes place have been generated. Medical, psychological, sociological research have all had an impact. Education of the young handicapped child is a relatively recent concern. The originators of early intervention programs looked to early regular educational models. The HCEEP (Handicapped Children's Early Education Projects) which were implemented in the 1960's and 1970's were funded partially on the basis of their being a "model" program which was unique and could serve to "demonstrate" the effectiveness of the approach for working with young handicapped children.

The majority of these early intervention programs have their theoretical roots in developmental or learning theories. The models derive from varying views of the etiology of handicapping conditions.

Comparisons of different early childhood educational models have frequently been made (Ackerman and Moore, 1976; Anastasiow, 1977; Boegehold, Cuffaro, Hooks, and Klopp, 1977). Authors select different models to examine, but most can be described as falling on a continuum. The elements which differentiate one model from another include: Curriculum content, structure and methodology. The extremes of either end of the continuum under each of these elements include:

A. Curriculum Content
    1. Based on Interests ↔ Based on Deficits
    2. Developmental Areas ↔ Skill Areas
    3. Developmental Sequences ↔ Skill Sequences
B. Structure
    Informal ↔ Formal
    1. Role of the Environment
        Facilitative Interaction ↔ Shaping through lessons

2. Role of the Staff
Facilitator ↔ Trainer

3. Role of the Child
Active Transactor ↔ Passive Receptor

C. Methodology

1. Child initiated ↔ Teacher initiated
2. Child-child interaction ↔ Teacher-child interaction
3. Natural reinforcers ↔ Sequence of reinforcers
4. Generalization and Application of skills ↔ Criterion referenced
5. Developmental growth observed ↔ Skills growth measured

An examination of specific models reveals further delineation of distinctions. Different authors may refer to the same model by seemingly discrepant names, but analysis reveals the underlying theoretical congruence.

CHILD DEVELOPMENT OR NORMAL DEVELOPMENTAL MODEL

Ackerman and Moore (1976) identify the "child development model" as falling at "informal" end of the continuum of models. Anastasiow (1978) refers to this as the "normal developmental model". This model emphasizes age appropriate skills, with skills being measured in relation to developmental norms. Both the content of the curriculum, and the environmental structure, and teaching methodology stress socioemotional development. Multiple activity areas are available. Children explore each of these "enrichment" centers, usually at their own discretion. Child-to-child interaction is encouraged. Areas such as art, science, blocks, play house are meant to allow social interaction, developmentally appropriate skill development, and discovery learning. The teachers role is to facilitate concept development through informal exchange, modeling and imitation. "Units" may be planned around specific topic areas, with children learning through observation, manipulation, and discussion of presented material and concepts. Specific learning targets are not identified as it is believed that direct teaching is not necessary, as the child will learn when developmentally ready.

THE MONTESSORI OR SENSORY COGNITIVE MODEL

Maria Montessori (1964) developed a model for education of young children based on the premise that given a well organized environment, tasks suited to their developmental level, and freedom to learn at their own pace, children learn spontaneously. In contrast to the normal developmental model, the total environment and the materials are carefullv sequenced and ordered. Lewis (1977) describes the curriculum in the Montessori Model as emphasizing sensory education, motor education, and language education, with academic learning being added after four years of age. Refinement of the senses through exercises of attention, comparison and judgment are stressed. Functional activities of daily life are taught in a specific sequence. Language development is encouraged through drill. The teacher plays the role of an observer, a resource person and facilitator of developmentally appropriate skill aquisition. Similar to the normal developmental model, the child paces himself. Learning takes place as a result of the relationship between child and materials. The teacher through observation determines what materials and concepts are appropriate to present to the child. The child's autonomous functioning and individuality are deemed of primary importance. The child is expected to make choices, take the initiative, risk failure, and grow socially and emotionally through this autonomous process.

THE COGNITIVE INTERACTIONAL MODEL OR COGNITIVE DEVELOPMENTAL MODEL

Variously named the verbal cognitive model (Ackerman and Moore, 1976), the cognitive developmental model, (Anastasiow, 1977) and the cognitive interactional model (Boegehold, et. al., 1977) the principles embodied in this approach derive from education and psychology. The theories and practices of educators such as John Dewey, Susan Isaacs, and Constance Kamii; psychologists such as Anna Freud and Erik Erikson; and developmental psychologists Jean Piaget and Emmy Werner have contributed greatly to this increasingly popular model. Development is viewed as a consequence of the interaction between the child and the environment, increasing the differentiation of cognitive structures. The child's genetic and biological make-up and maturation are important considerations. Development progresses through stages which are invariant, sequential, and hierrachical though the rate of development is variable.

Learning takes place as a result of the interaction between the child and the environment, between maturation and the environment. As a result of this interaction cognitive structures or schemata develop and are constantly changing to become more complex and differentiated. This reorganization of mental structures occurs when a person spontaneously acts on the environment, and thus "assimilates" or incorporates new information and accommodates or adjusts his schemata to make sense of the environment. Piaget discusses stages of development. The first stage of sensorimotor development and the second stage, pre-operational are most relevant for infant and preschool programs. The concrete operational and formal operational stages are significant for school age children. Regardless of the stage at which a child is functioning however, active involvement on the part of the child is critical for learning to take place (Phillips, 1975).

The child is encouraged to come up with interesting ideas, problems and questions and to observe relationships and similarities and differences. Emotionally the goal is for the child to develop independence, initiative and self confidence, while at the same time developing an understanding of the feelings and rights of others (Kamii, 1975).

In terms of curriculum, the cognitive interactional model views competence as being more than the total number of skills demonstrated by a child. How the child uses skills and knowledge to solve problems in his environment is important. The meaningful integration of concepts into the child's total cognitive structure in relation to all the objects, people and events that he encounters is the goal. Cognitive development is emphasized, but in relation to motor, language and social emotional development.

The environment is arranged in centers similar to those in the normal developmental model. The difference is the type of facilitation the teacher does with the children. The activities or "key experiences" (Hohman, Banet and Weikart, 1979) in which the child engages are important. At home or at school, the parent or teacher may present specific objects, model their use, encourage exploration by the child and question about its properties, or ask provocative questions to encourage higher level problem-solving (Anastasiow, 1977). Opportunities for practice and generalization of skills and concepts is provided through a variety of manipulative activities and constant verbal exchange. The role of play is also seen as critical and basic to maturation and development.

A major difference in methodology between the cognitive interactionist and the behavioral point of view is the role failure plays in learning. The behavioral model views constant success as important, while the cognitive interactionist model perceives failure as critical to learning. When the child experiences something which does not "fit into" his/her existing perceptions of the world, it becomes necessary to modify cognitive structures to obtain a new understanding. Thus, failure (on a task which is slightly novel and is a developmentally appropriate challenge) creates the incentive for learning (Furth and Wachs, 1975). The teacher can facilitate this growth by arranging appropriately challenging tasks and asking questions which cause problem-solving to take place.

Philosophically, some of the goals of a developmental-interactionist program include:

1) promoting the child's ability to impact on the environment
2) promoting the child's ability to order experience
3) promoting the child's functional knowledge of the environment
4) promoting internalized impulse control and ability to cope with conflicts
5) promoting mutually supportive patterns of interaction (Biber, Wickens, and Shapiro, 1971).

BEHAVIOR MODIFICATION OR PRECISION TEACHING

The behavioral approach to education of handicapped children is based on the premise that learning will take place most quickly when the environment is controlled and the role of the teacher is to shape or influence the child's adoption of specific behaviors. All behaviors are perceived as:

-learned

-observable

-culturally determined

-desirable or non-desirable (Anastasiow, 1977).

Behavioral programs rely heavily on continuous data collection as it is necessary to objectively specify target behaviors, or terminal behaviors that are to be produced. It is important to:

-identify and name the desired behavior

-define the conditions under which the behavior is to occur

-define the criteria of acceptable performance (Mikulas, 1978).

The teacher's responsibility is to specify the above targets, conditions and criteria and to measure and plan growth. The methodology employed relies heavily on task analysis, or a break-down of skills into their component parts.

Each child's instruction is begun at the appropriate step or level to increase the probability of the child's success and proceeds sequentially through all the steps and targets designated in the child's program. This method gives the teacher explicit direction in determining skill content through structure and order. The evaluation of progress is facilitated by specific criteria for determining successful performance. The precise delineation of targets, conditions and criteria facilitates the replication of the child's instructional program by other staff or parents (Fallen, 1978).

Techniques employed include administering rewards contigent upon correct responses (various types and schedules of reinforcement are used). Cueing, prompting, shaping, modeling are all employed as needed to train a specific target skill. Elimination of maladaptive behaviors may also be program targets and training may utilize the above methods in addition to punishment, time out, extinction, counterconditioning, aversive conditioning, flooding, etc.

Behavioral approaches have been used successfully with all types of children, but have been found to be particularly successful with severely and profoundly handicapped children.

DEVELOPMENTAL LEARNING OR COGNITIVE LEARNING MODEL

The developmental learning or cognitive learning model attempts to take the best from the cognitive developmental and behavioral models. The principles of Piaget and other developmentalist's are combined with measurable behavioral objectives. An attempt is made to break down sensorimotor or preoperational experiences into developmental sequences which can be trained. The role of play is important to augment the formal program and encourage generalization of skills through functional practice. Thus the concepts of "assimilation" and "accommodation" are combined with "task analysis" and "reinforcement" in a structured yet facilitative environment. Experimentation with this approach is relatively recent, and programs vary in the amount and degree of "training" versus "facilitation" which takes place. The goal, however, is to maximize skill development, spontaneous environmental interaction, and generalization of functional application of skills.

CURRICULUM/ASSESSMENT

-content or skills
-congruence
-integration
-usage

CONTENT

Curriculum in its broadest sense is the content of what is taught in the program. Evaluation entails determining what skills and abilities a child demonstrates at any given point in time. Both curriculum and assessment will be discussed in depth in subsequent chapters, and thus will only be discussed briefly here as they relate to philosophy.

Curricula differ in the content or skills to be taught, the order or sequence of content presentation, the methods recommended for teaching the content, and the manner in which progress is recorded. Variations of each are considered in Chapter 6. Basic consideration should be given to philosophical congruence, curricular integration and appropriate curriculum usage.

CONGRUENCE

The curriculum which is chosen or developed should relate synergistically to the philosophical model which is selected and also to the consequent assessment measures utilized. Often programs profess to operate under a specific philosophical model, yet the curriculum and assessment measures are inconsistent. For example, program staff may determine they believe that children learn best through a cognitive developmental approach, yet they may choose the Portage (1976) curriculum and the Behavioral Characteristics Progression (1973) as an evaluation tool (both behaviorally oriented instru-

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ments). It is feasible to combine elements of various models into a program design, but staff need to understand the underlying philosophical differences and make sure that necessary modifications are made. The concepts considered important in the cognitive developmental curriculum, may not be adequately addressed or appropriately developmentally sequenced in a behaviorally oriented tool. If specific concepts or skills are to be included as important targets for learning, more than one type of evaluation instrument may be necessitated.

CURRICULUM INTEGRATION

A program could incorporate a cognitive interaction time, developmental skills taught through structured behavioral principles, and precision teaching for vital skills which necessitate specific intervention. The curriculum chosen for these various elements of the program will be distinctive, and staff should have a thorough understanding of how to maximally utilize each and be able to determine which approaches are most effective for specific children's needs. For example, a multiply handicapped child who is blind, severely mentally retarded and hemiplegic may not be able to interact in a block area if left alone. However, cognitive interaction through play can be accomplished if effectively facilitated by the teacher. This child may also benefit from more structured teaching of toileting skills and precision teaching of speech sounds.

APPROPRIATE USAGE

No one curriculum is appropriate or perhaps "most" appropriate for all handicapped children. The severity of the handicap and the developmental level of the children are important. Some curricula have been designed for mildly involved or disadvantaged children. The types of activities in these curricula often require a higher level of cognition and language than can be expected from more severely involved children. The assessment checklists which accompany these curricula often have wide developmental gaps between items. These checklists are frequently misused by staff with lower functioning children. A "minus" score on a checklist item becomes the child's objective. If there is a large gap between developmental milestones on the assessment tool, the objective may be too high for the child. The teacher may persist in working on an objective which is inappropriate. There is also a possibility the curriculum items may be non-developmentally sequenced or may contain totally unrelated items. Obviously, a knowledge of normal development and task analysis would be beneficial. However, choosing a more appropriate assessment instrument and curriculum would greatly reduce staff planning time and facilitate consistent evaluation across staff.

SITE

-home based
-center-based
-combination
-continuum

Early intervention programs are most commonly either home-based, center-based, or a combination of home-and-center-based. As with the staffing pattern, program model, and curriculum, the setting reflects the program philosophy. Inherent in the decision to offer a program at home or in a center are certain basic beliefs about the role of family, staff and learning environments.

Shearer and Shearer (1972) have delineated the reasons for delivering services to handicapped children in their homes.

1. Learning occurs in the child's natural environment, therefore there is no difficulty with having skills transfer from home to school.
2. Parents have direct and natural access to behaviors as they occur. Therefore, functional objectives can be set and cultural considerations can be taken into account.
3. It is more likely that learned behaviors will generalize and be maintained if taught in the home by the parent.

4. There is more opportunity for all of the members of the family to become involved and participate in the child's program.
5. Parents have access to the child's full range of behaviors, not just what is evident in the classroom. Therefore, they can work on skills for which there would be no opportunity in the classroom.
6. Training parents, who are the child's natural reinforcing agent, will allow them to develop skills to deal with new behaviors as they arise.
7. Individualization of the child's goals and objectives is operational, as it is necessary as a result of the setting (p. 337).

Inherent in this philosophy is the belief that parents can be and are the child's best teachers, that the home is a stimulating learning environment, and that staff can play an educational role for the entire family.

Home based programs are often necessary for other than philosophical reasons. Geographical and demographic considerations sometimes make home-based programs the only viable option.

Center-based programs, on the other hand, have a different set of advantages and philosophical underpinnings.

1. All families have a common setting for the child. Therefore, all children have access to the variety of toys and materials available at the center, which may not be found at home.
2. A wide range of services is available, including counseling and parent groups.
3. Parents have an opportunity to view tapes, books, and other materials to aid them in understanding their child's handicap and how to best facilitate development.
4. Children are exposed to other children and thus have an opportunity to develop social skills which are important to their overall development.
5. Children have an opportunity to have individual therapy and their programs may have input from many disciplines.
6. Children have an opportunity to learn to interact with adults other than their parents.
7. Parents have an opportunity to observe and perhaps work with children other than their own.
8. Parents have an opportunity to talk to other parents and share feelings and experience, thereby gaining emotional support.

9. Children may receive more actual program time.

The home and center-based programs profess to have the advantages of both settings. Depending on how much time is spent in either option and what activities take place, this may or may not be the case. Combined programs may also be a little more expensive due to dual transportation expenses. It is perhaps ideal to have an individualized program which can provide either or both as is deemed necessary and most beneficial to the child and the family.

CONTINUUM OF SERVICES

The environmental options available include more than home-based, center-based or combination programs. Public Law 94-142 sets forth the necessity to provide programs for handicapped children in the "least restrictive" or most "normal" environment. A continuum of most restrictive to least restrictive might include the following:

----Institution
-----Home-bound (school age)
------Segregated school
-------Regular school self-contained class
--------Self-contained class & integrated activities
---------Integrated class & resource room activities
----------Integrated class & support services activities
-----------Integrated class & integrated activities

In the case of handicapped infants, home would be considered a natural environment. If a more "therapeutic" environment is deemed appropriate the infant may attend a program either in segregated school or segregated classroom within a normal school. Occasionally integrated infant programs are set up.

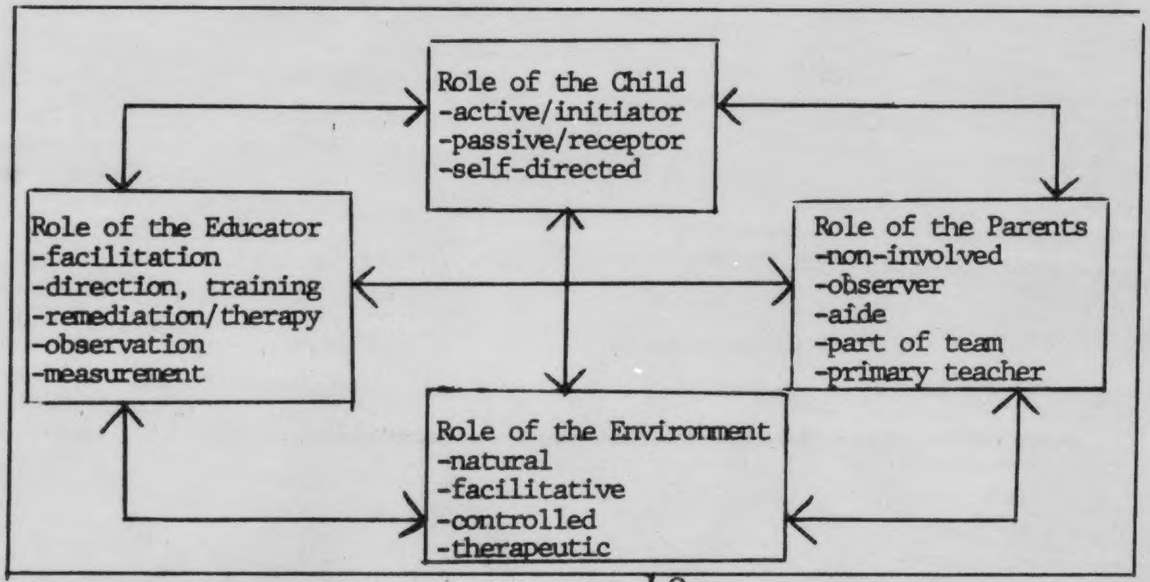
Each of the "steps" on the continuum has advantages and disadvantages and research exists to support or reject its success in serving children. The problem facing infant and preschool programs, particularly in public schools, is that frequently there is no "regular" infant or preschool class with "normal" children with whom to integrate the handicapped children.

Creative alternatives can be found. Integration of siblings or staff children can provide important normal models. Cooperative efforts with local nursery or day care establishments can also provide more "normal" environments through exchanges or working out half days in special preschool and half days in day care (for parents who work). Whenever possible, handicapped children should be provided opportunities to interact in meaningful ways with normal children. This may necessitate facilitation and some training of the nursery school or day care staff and the normal children. Whenever efforts at mainstreaming are undertaken they should be carefully planned to maximize the possibility of successful interaction.

NATURE OF THE PROGRAM

The third component of the process model for determination of the service delivery system necessitates looking at the interaction between the child, the staff, the parents and the environment. The nature of the interaction between these elements (See Fig. 1, pg. 73) flows directly from the nature of the program philosophy, specifically from the staffing pattern selected, the theoretical model, the curricula utilized and the setting of the program. Figure 4 illustrates the alternatives which may emerge under each element.

Figure 4. NATURE OF THE PROGRAM


Role of the Child
-active/initiator
-passive/receptor
-self-directed
Role of the Educator
-facilitation
-direction, training
-remediation/therapy
-observation
-measurement
Role of the Parents
-non-involved
-observer
-aide
-part of team
-primary teacher
Role of the Environment
-natural
-facilitative
-controlled
-therapeutic

How the educator and other staff perceive of their roles directly affects how the environment is arranged and thus the child's role in that environment. The role of the parents is often determined by these perceptions as well.

ROLE OF THE EARLY CHILDHOOD SPECIAL EDUCATOR AS PART OF A TEAM

The role of the teacher is critical to program design, and will vary regardless of the team approach which is utilized. The teacher is responsible for planning and implementing the child's educational program and measuring its success. Depending on the educational model on which the program is based, this role will vary greatly. The early childhood special educator may be viewed as a facilitator, teacher, "engineer", or therapist. (See Figure 5)

Figure 5. Role of early childhood educator

Educator as facilitator	-The educator facilitates the child's interaction with the environment. Modeling, demonstrating, questioning. Child plays a major role in decision-making around activities. Discovery learning is vital.
Educator as teacher	-The Educator "teaches" or transfers knowledge and skills. The child accepts information. Repetition and practice are important.
Educator as "Engineer"	-The educator manipulates the environment to ensure success. Modeling, shaping, and reinforcement are utilized. Measurement is precise and ongoing.
Educator as therapist or educational synthesizer	-A clinical or remediation approach is utilized based on developmental and behavioral principles. Knowledge and skills of various disciplines are integrated. Combination of approaches may be used.

ROLE OF THE CHILD AND THE ENVIRONMENT

The role of the child within the environment can be seen to eminate from the definition of staff roles. Figure 6. shows the relationships among the various elements.

Figure 6. Role of the Child and Environment

Role of Educator	Role of Child	Role of Environment
Educator as facilitator	Child is active-initates own activity. Play is vital to development and learning. Manipulation, comparison, discovery is encouraged. Child-interaction is important for cognitive and social/emotional development.	Self-initiated interaction with environment is key. Objects, people, events are foundations for cognitive restructuring. Arrangement of the environment to maximize discovery of concepts is important.
Educator as teacher	Child is a receptor of information. The relationship between the teacher and the child is the most important for learning. Imitation after demonstration is important.	The environment is structured to provide the needed information in the appropriate sequences. Repetition of presentation of information, objects, etc.
Educator as "engineer"	Child is a receptor of information and is shaped to perform desired behaviors. Child may be involved in measuring his/her own progress.	The environment is the source of reinforcement and can be structured to ensure learning and success. Objects, persons. and events are structured to reinforce desired behaviors.
Educator as therapist or educational synthesizer	Child may be both active and a receptor. Physical manipulation of the child may take place. Reinforcement of desired behaviors is important. Self-iniatiation of activities is also essential to maximize generalization. Play is also important.	The environment needs to be structured at times and unstructured at others. Environment is reinforcing and stimulates exploration.

THE ROLE OF THE PARENTS

The role of the parents deserves some further discussion, as it may vary regardless of the preceeding interrelationships. Parent involvement is explored extensively in Chapter 7, and thus is only briefly discussed here as it relates to the development of a service delivery system. The philosophy of a staff is reflected in their perceptions of what the parents' role in the program should be. It is also highly dependent on how the parents themselves view their role. The parents and/or the staff may find one or more of the following to be appropriate roles for the parents:

1) Non-involvement. Occasionally staff or parents do not feel it is in the best interest of the child for the parents to be involved in the program. The parents may not feel comfortable in observing or working with the handicapped child. The parents' working schedules may not allow for involvement. If highly specific therapy is needed which is unpleasant for the child, a staff person may feel that it is best for the parent to not observe the sessions. It should be noted that at times non-involvement may be the best "therapy" for a parent, and many parents do not feel comfortable "teaching" their child. As a general rule, however, non-involvement should not be encouraged. If enough options are available, parents will be more likely to be able to find a meaningful mode of participation. Bronfenbrenner (1975) has noted that those programs which teach parents how to work directly with their children are the most successful.

2) Parent as observer. Parents can learn a great deal about their child and how to deal with the child at home by observing capable staff working with their child. Staff can model and demonstrate positioning, feeding, teaching specific skills and managing behavior. Parents may then try these techniques later at home. Such an informal method of working with parents is non-threatening and is often a means by which

to gradually increase the involvement of a hesitant or fearful parent. Parents also indicate that they have benefited greatly by observing children other than their own. This helps them to gain a better understanding of the strengths and weaknesses of their own child. A handicap which seemed devastating to the family, may be viewed as "not so bad" when compared to more severely involved children in the program.

3) Parent as aide. The next step toward a higher level of involvement is aiding in the home or classroom. As the teacher or therapist works with the child or children, the parent assists with specific program tasks. This level allows for greater learning, as staff can provide continual feedback and encouragement for demonstration of good teaching techniques. Often parents rotate the job of aiding in a classroom situation, thus allowing all parents to participate. The parent-as-aide also provides an often needed extra set of skilled helping hands.

4) Parent as partner. As the parent's become more involved, particularly in home-based programs, the parent becomes a partner to the staff. Intervention techniques are taught to the parent, with the parent practicing the techniques in front of the staff. Staff provide ongoing feedback and support. Parents suggestions are sought and program planning becomes a joint effort, with the parent a key member of the team.

5) Parent as teacher. After a time, many parents become very proficient at intervention. They are able to plan a program with assistance from staff and can follow-through on all intervention. The staff serve primarily as consultants and a base for needed emotional support. Staff provide ongoing evaluation, therapy and necessary materials and equipment. Parents at this level of involvement are

often tremendously valuable resources to assist other parents who are struggling with adapting to living and working with a handicapped child.

It is important for staff to discuss their philosophy regarding the role of parents in the program. A variety of alternatives need to be available in order to ensure that the program is individualized to meet the needs of families as well as the need of children.

INTEGRATING PHILOSOPHICAL COMPONENTS

The development of a service delivery system based on a consistent philosophy is not an easy task. The nature of the population, the nature of the staff's beliefs concerning learning and development, and nature of the staff's perception of roles all are determinates of a philosophy of early intervention. A step-by-step analysis of each of the previously discussed elements is essential to program planning.

To summarize, each of the following elements need to be assessed:

1) Funding sources-which may affect who may be served.
2) The types, degrees, ages and number of handicapped children needing service.
3) The background of families to be served.
4) The geographic distribution of families to be served.
5) The services provided by other agencies which impact on young handicapped children.
6) The services to be provided to young handicapped children.
7) The staff needed to provide services.
8) The staffing patterns desired.
9) The theoretical model of learning espoused.

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10) The assessment instruments and curricula selected.

11) The setting - including facilities and equipment.

12) The interactive nature of child/staff/environment/parents.

After consideration and determination of each of these major elements, the details of job responsibilities, scheduling, specific instruments, materials and equipment will evolve from these philosophical foundations. Many problems such as dissention, tension among staff may be avoided if this process is followed in the initial program planning stages.

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FOUR

COORDINATING COMMUNITY RESOURCES

Jimmy J. has cerebral palsy and has a need for reflex integration and activities to develop fine and gross motor skills. However, the school district does not have a physical therapist in this rural district.

Sally L.'s mother is a single parent, with an eighth grade education and no job. Sally is being neglected at home, both physically and mentally. Sally's mother needs a variety of services before she can be an effective mother to her developmentally delayed daughter. School district personnel realize that although their responsibility is to provide services to the child, in order to be effective, Sally's mother needs education, job training, and homemaking services.

Freddie W. has chronic health problems, would benefit from corrective surgery on his spine, and needs a prosthetic devise. The family does not have the resources to adequately meet Freddie's needs.

Barbara's family is having a difficult time handling the multiple responsibilities associated with their daughter's severe handicaps. Barbara's mother has had a nervous breakdown and her father, working two jobs, is physically and emotionally unavailable to help. The family would like to place Barbara in a residential setting temporarily while they deal with family crises. The school district staff is unaware of any options other than the state institution which is in another city.

The above cases illustrate a few of the innumerable problems which face school district staff every day:

1. The need for more specialized personnel to supplement and enhance school district services.
2. The need for more services for a child's family.
3. The need for support services not ordinarily provided by education.
4. The need for knowledge of existing community resources.
5. The need for knowledge of local, state, and federal agencies who can provide assistance.

One way these needs may be addressed is through a coordinated community effort which is child-oriented rather than self-serving.

A CONTINUUM OF SERVICES

A major goal of most agencies serving young handicapped children and their families is to provide high quality care and treatment in a supportive environment. Each agency attempts to provide a broad spectrum of services to meet both the child's and the family's needs. The needs of both may be numerous, as a result of the lack of traditional support systems in our society.

"In today's mobile culture, many families have not established adequate resources and social networks (relatives and friends) to provide necessary support to meet vital life problems; therefore, a formal community-based intervention system is necessary" (Pollard, Hall and Keeran, 1979, p. 17).

Clearly, it is impossible for any one agency to provide a total continuum of services to deal with problems related to mental health, education, medical, social and financial problems that may impinge upon a family of a handicapped child. No one agency could afford to provide all needed services. These families may require a wide variety of services from different agencies. Most families do not know how to go about locating and organizing the maze of existing community services, and, in fact, may not be aware of many services which are available. Many may not even be aware of the extent of their own and/or their child's needs. There is a demand for a system which has well defined and highly integrated resources.

"Effective access to services requires each agency in the service delivery system to serve as a resource to the individual and the family, and to provide linkage to all other services within the system. A high degree of communication, cooperation, and coordination is therefore required among all the elements of the service delivery system" (Pollard, Hall and Keeran, 1979, p. 7).

RATIONALE FOR INTERAGENCY COORDINATION

1) One of the most important reasons for interagency coordination is the elimination of duplication of services. In early childhood special education, many agencies may provide similar services from different funding sources. Screening, for example, may be done by the public schools using P.L. 94-142 monies; by the local health agencies using EPSDT monies; by the department of institutions through local community center boards using Development Disabilities monies; by Health and Hospitals through visiting home nurses Maternal and Child Health monies; by University Affiliated Facilities using Personnel Preparation and Training monies; and so on. Coordination of the screening and other services would eliminate much duplication and free up dollars to be used for other needed services.

2) Interagency coordination will also provide a clearer picture of where there are gaps in services. For example, a review of resources may reveal a paucity of mental health services for the emotionally disturbed preschool age child. Cooperative efforts can then be developed utilizing existing resources in the Headstart programs, public schools, mental health centers, and other community agencies. Identification of gaps in services can thus lead to

the initiation of efforts to provide needed services.

3) The reduction of duplication of services and elimination of gaps in services would lead to a more effective use of personnel and resources and facilitate the development of a total continuum of services for handicapped children and their families.

4) Interagency cooperation could also provide for horizontal as well as vertical extension of the service delivery system. Horizontal extension would allow for broadening of services, while vertical expansion would mean the addition of an increased number of services. In other words, an agency would have more alternatives in terms of how they meet an individual child and family's needs. Elder (1979) describes how interagency agreements could assist the schools in meeting the mandates of P.L. 94-142.

"In their federal government implementing regulations, P.L. 94-142. Section 504 of the Rehabiliation Act of 1973 require that each handicapped child must be provided all services necessary to meet his or her special education and related needs. If this statement were read as mandating that schools must assume all costs, it would place an impossible financial burden on school districts to pay for services they have never before provided and can ill afford. However, there is no requirement in any of the legislation that schools can plan only services in the IEP which the schools pay for. That is, nothing in law or regulations prohibit schools from meeting IEP requirements by utilizing other nonschool community services and funding where they are available. Arrangements with other sources of funds at any level, cost-sharing across agencies, and even tapping the too often overlooked insurance benefits which pay for needed services should be worked toward in developing interagency agreements. By developing joint funding in interagency agreements, resources can be maximized and the question of which agency provides the first dollar for services can be resolved" (Elder, 1979, p. 204).

By utilizing other available monies, or cost-sharing, the school districts can coordinate a wide range of services for a child. "The options which can be exercised by local leadership can be multiplied by carefully designed interagency efforts" (Audette, 1978. p. 3).

5) The coordination of resources not only meets individual and family needs, it also meets community needs. Taxpayers are demanding wiser expenditure of tax money. Proposition 13 in California is a clear directive to state and local agencies to develop unified service delivery systems, to simplify the bureaucracy and to eliminate "waste" of the tax payers' money. There is not likely to be a large increase in dollars available for human services. Consequently it is imperative that coordination take place to ensure maximum use of services.

6) Coordination of existing resources also facilitates planning for effective utilization of future resources. Coordinated efforts enables comprehensive planning. It also allows for joint application for grants, with increased probability of funding if interagency coordination is demonstrated. For example, if a population boom is expected in an oil shale area, the cooperative examination of existing resources and projection of needs for the future may allow time for additional monies to be obtained from a federal or other source. Thus, astute planning may serve the community from being overwhelmed by human service needs with very few resources to meet the growing demand.

7) The coordination of resources through the public schools allows parents and service providers a central facilitation agency. The schools are the one agency the child will relate to until he/she is twenty-one years old. The coordination of intake, referral, service deliver and follow-up by the schools will allow for consistent program management. If interagency agree-

ments exist with a broad range of agencies the child and family should have access to all needed services through one organization in the service delivery system. An enormous amount of expertise exists in most communities scattered throughout the various agencies. Appropriate utilization of those personnel through effective interagency communication can maximize the intervention efforts. The various agencies act, in effect, like an interdisciplinary team on behalf of handicapped children and their families.

8) As a result of increased cooperation and communication, interagency coordination helps build a support base for the program. As representatives of other agencies become familiar with the services which are being provided; as they come to invest time and resources in establishing a high quality continuum of services - they will not want to view the demise of needed services. Interagency coordination can be a basis for good public relations and continuing support for early intervention programs for young handicapped children.

9) The coordination of services is becoming a mandate through federal legislation and regulations. The "time" for interagency agreements may have arrived. As a result of all of the above benefits at no increased cost, many legislators and policy makers are beginning to mandate interagency efforts. Particularly at the federal level, joint policy statements are being developed. The Bureau of Education for the Handicapped, the Bureau of Community Health Services, and the Rehabilitation Services Administration and an increasing number of other agencies are encouraging interagency coordination and, in many cases, requiring grant recipients to incorporate interagency agreements in their proposals.

At the state level, as the dollar squeeze becomes tighter, many budget committees will look to interagency agreements as a means by which to compress services and utilize funds more efficiently. While the pressures appear to be coming from the federal and state levels, the development of workable agreements must begin from the local level.

PHILOSOPHICAL CONSISTENCY

The development of interagency agreements can be compared to the process of developing an I.E.P. for a handicapped child (NASDSE, 1980). In the school, the interdisciplinary team evaluates the childs strengths and weaknesses, determines his/her needs, establishes goals and objectives and plans activities to remediate problems and facilitate growth. The I.E.P. is reviewed annually and continually modified as the objectives need to be updated or the plan is not working effectively. In the community, the multiple agencies within the service delivery system are analogous to the interdisciplinary team. The interagency team looks at the whole system, (like the whole child) analyzes the strengths and weaknesses, plans a course of action stating who will be responsible for each part of the plan to meet the stated goals and objectives. The interagency plan (like the I.E.P.) is monitored and evaluated throughout the year and changes are made as needed to ensure maximum effectiveness.

Stated another way:

"A properly designed interagency agreement reflects the constraints, requirements, and discretionary authority of each participating agency. Such a design is based on an analysis of common purposes across agencies and acceptable options for meeting those responsibilities through cooperative efforts." (Audette, 1978, p. 2).

BARRIERS TO COORDINATION OF RESOURCES

The benefits just described would lead one to believe that all administrators would be actively pursuing the development of interagency agreements. The fact is, that there has been great reluctance on the part of state and local level agency heads to become involved in interagency efforts. Why the hesitation?

Pollard, Hall and Keeran (1979) have described the basis for this reluctance to develop cross-agency agreements. They list the barriers to coordination as:

1. The competitiveness of long established institutions.
2. The lack of an organizational structure that brings agencies together around areas of mutual interest.
3. The parochial interests of agencies and organizations that make them myopic to the needs of the broader community.
4. The lack of experience in the techniques of coordinated planning.
5. Awkwardness in interdisciplinary communication and lack of respect among many professional groups whose skills are needed by the handicapped.
6. Failure to recognize that programs for handicapped persons are coequally a major responsibility of several government agencies at federal, state, and local levels. e.g., Health, Education, and Welfare as well as Mental Health Rehabilitation, Housing and Employment.
7. The temptation of system delivery designers to become so preoccupied and fixated on the "system design" that they lose sight of the functional whole of the system and of the individual agencies working to meet the needs of handicapped persons (pp. 7-8).

Elder (1979) discusses additional factors which hinder interagency coordination. He states that resistance on the part of agency personnel to more work is an important factor. The development of interagency agreements is time consuming and often difficult. Unless all parties perceive the benefits to be accrued they will not see the value of the effort to be expended. The attempt to protect "turf" is seen as another significant factor. Problems with variations in client eligibility criteria and ethical issues around confidentiality of information are also realistic concerns. Differences in terminology or "professional jargon" also makes communication difficult. The definitions of program plans, for instance, are variously called individual education plans (I.E.P.'s) by education, individual program plans (I.P.P.'s) by institutions, and individualized rehabilitation plans by vocational rehabilitiation.

Each of these words has a slightly different meaning to the professionals from these agencies. Lack of clarification of terminology is often a barrier to interagency communication. Elder also indicates that the segregated and fragmented delivery system thwarts efforts at coordination. The deficiency in communication and coordination among and across federal and state agencies serves as a poor model for local agencies. Without effective exemplars local agencies do not perceive the rewards to be gained, nor do they have any pattern to follow in initiating the complex interagency planning process. Lastly, all of us resist change when we are uncertain of the benefits or have to drastically alter long standing processes and procedures.

OVERCOMING BARRIERS

The importance of the above problems should not be minimized. A successful coordination effort can be accomplished by careful planning and consideration of possible barriers. The reality is that starting small, with the needs of individual children as the initial impetus for coordination may be necessary. People at the program level need to be involved in planning for coordination. A facilitor from each agency should oversee the process as it evolves, working with both program and administrative staff. The facilitator should work on the project full time or else have the development and implementation of the agreements as a major function of his job responsibilities. The political nature of the process demands a sensitive, astute person who can work successfully with many different personalities. The role of each of the parties needs to be clearly delineated at the beginning of collaborative efforts. This demands the facilitators have knowledge of existing resources, services provided, funding mechanisms, and regulations. Commitment needs to be secured from agency heads. If full support is not obtained agreements can break down at the most important implementation level (or anytime prior to that).

An understanding of the dynamics of change is critical. The resistance to change can be overcome by careful orchestration. Elder (1979) suggests the following steps:

1) ceremonialize a major change
2) form internal agency groups to deal with change
3) control the rate of change
4) make short term, low profile goals
5) provide inservice training on new processes or procedures (p. 198-200).

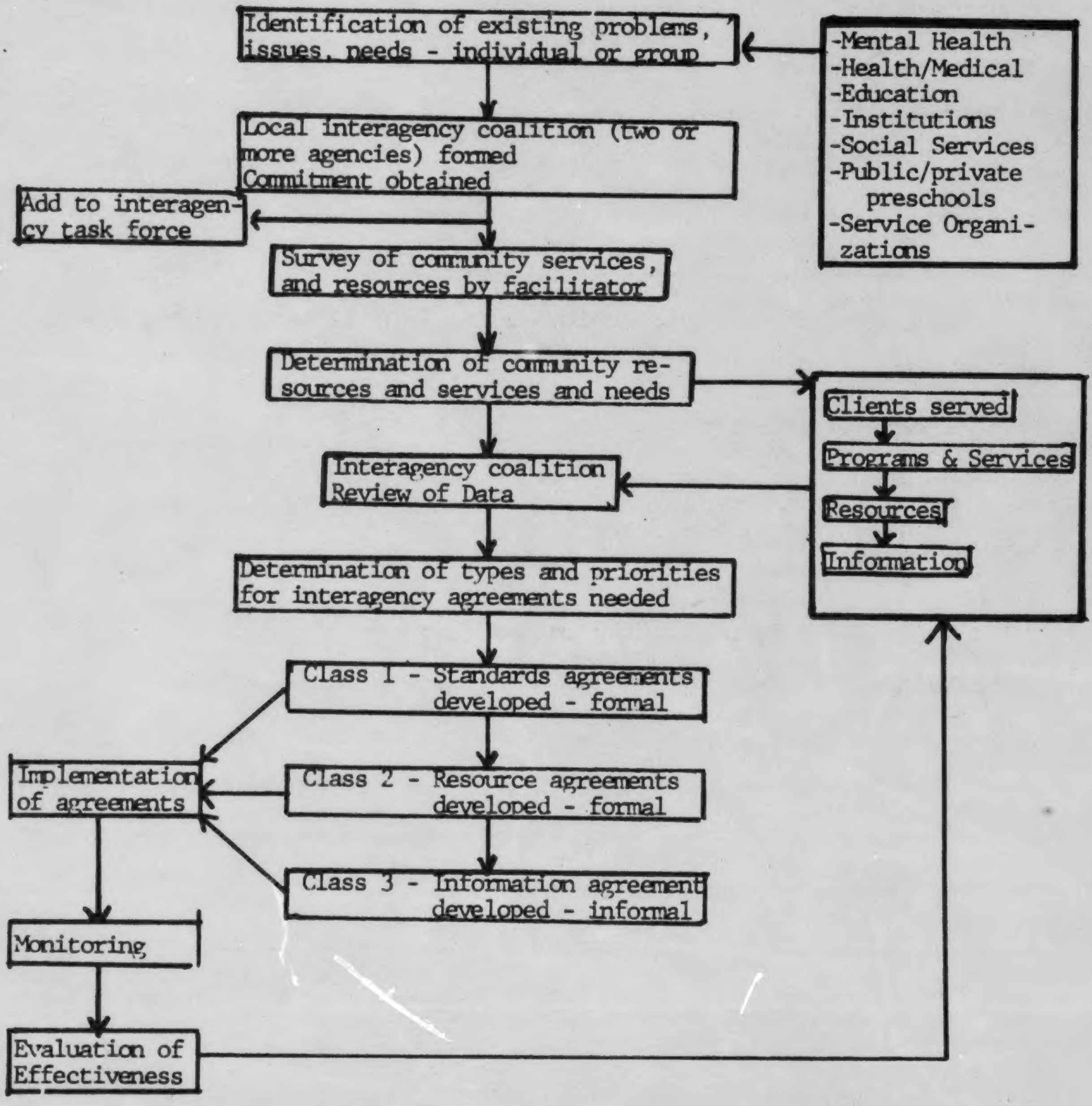
GETTING STARTED

One of the first steps is to determine what agencies are most likely to have interrelated services. Representatives from each of these agencies need to meet to discuss the issues which are placing demands on them. The benefits of possible interagency cooperation and coordination are more likely to be seen after a discussion of mutual concerns and problems which are unsolved. Once needs have been identified, relating to individual children and groups of children, it is possible to then form an interagency coalition to gather and examine data to aid in problem solving.

Initial representations from the following community groups and agencies might include, but not be limited to:

Figure 1

PROCESS MODEL FOR DEVELOPING INTERAGENCY COORDINATION


Identification of existing problems, issues, needs - individual or group
-Mental Health
-Health/Medical
-Education
-Institutions
-Social Services
-Public/private preschools
-Service Organizations
Local interagency coalition (two or more agencies) formed
Commitment obtained
Add to interagency task force
Survey of community services, and resources by facilitator
Determination of community resources and services and needs
Clients served
Programs & Services
Resources
Information
Interagency coalition
Review of Data
Determination of types and priorities for interagency agreements needed
Class 1 - Standards agreements developed - formal
Class 2 - Resource agreements developed - formal
Class 3 - Information agreement developed - informal
Implementation of agreements
Monitoring
Evaluation of Effectiveness

-Local Department of Health
-Other health facilities (clinics, hospitals)
-Local medical personnel
-Community center boards
-Local departments of social services
-Head Start
-Parent groups
-Public and private schools
-Other private or public agencies serving the handicapped
-Public service organizations

(From Child Find, A Handbook for Implementation, Colorado Department of Education, 1978, p. 10)

The flowchart, Figure 1, on page 116 outlines the process by which the coalition can operate. After the initial formulation of roles and responsibilities, the core coalition can begin to gather data from their own and other important community service agencies and organizations. Figure 2 is a suggested resource list from the Colorado Child Find Handbook, (1978).

Figure 2

COMMUNITY RESOURCES

Public Agencies

________ Colorado Department of Education
________   Special Education Services
________ Colorado Department of Health
________   Division of Family Health Services
________ Colorado Department of Social Services
________   Division of Title XX Services
________   Family and Children's Services
________   Services to Children
________   Specialized Services for Mentally Retarded
________   Day Care
________ Division of Medical Assistance
________   Division of Medical Assistance
________   Division of Vocational Rehabilitation
________ Colorado Department of Institutions
________   Division of Youth Services
________   Division of Developmental Disabilities
________   Division of Mental Health
________ Boards of Cooperative Educational Services
________ Schools Districts
________ Child Development Centers
________ State Home and Training Schools
________ Colorado School for the Deaf and the Blind
________ Head Start
________ Governor's Council on the Handicapped
________ Colorado State Board for Community Colleges and Occupational Education

Social and Civic Organizations

________ PTA and PTO
________ Big Brothers, Incorporated
________ Big Sisters of Colorado, Incorporated
________ Neighborhood Action Centers and Opportunity Schools
________ Human Services, Incorporated
________ Interfaith Task Force
________ Emergency Good Neighbor Services
________ Goodwill Industries
________ Help Foundation
________ United Way
________ Cultural Organizations (Native Americans United, Inc.)
________ Child Birth Preparation Association of Colorado, Inc.
________ Children's Education Fund Centers
________ Veteran's of Foreign Wars
________ Senior Citizen's Group
________ Salvation Army
________ Volunteers of American
________ Attention, Inc.
________ American Legion
________ American Youth Hostels
________ Jaycees
________ Knights of Columbus
________ Masons
________ Elks
________ Eagles
________ Shriners
________ Moose
________ Lions
________ International Order of Odd Fellows
________ Local Sororities and Fraternities
________ YMCA, YWCA
________ Boy and Girl Scouts
________ Campfire Girls
________ Red Cross
________ Kiwanis
________ Rotary
________ Local Women's Groups
________ Optimists
________ Soroptimists
________ Religious Community Centers, Services and Organizations
________ Colorado Federation, The Council for Exceptional Children
________ Colorado Association for Retarded Citizens
________ Colorado Epilepsy Association
________ Colorado Association for Children with Learning Disabilities
________ Planned Parenthood
________ Easter Seal Society

______ International Rehabilitation Association
______ Colorado Association of the Deaf
______ March of Dimes
______ United Cerebral Palsy
______ Citizen Advocacy Program
______ National Association for the Advancement of Colored People (NAACP)
______ Hispanic or Chicano Organizations
______ Religious Charities
______ Parent Organizations
______ Colorado Association for the Education of Young Children
______ Employee Associations
______ Medical Society
______ Dental Society
______ Professional Women's Associations
______ Local and Community Hospitals
______ Colleges and University Special Education Departments
______ Day Care Programs
______ Head Start
______ Preschool Programs
______ Parents of Handicapped Children
______ Mountain Plains Regional Center for Services to Handicapped Children
______ Farm Bureau
______ Chamber of Commerce
______ Four-H Clubs
______ Labor Unions
______ Business Associations
______ Colorado Society for the Prevention of Blindness
______ Association of Childhood Education
______ Colorado Education Association
______ Colorado Federation of Teachers
______ Colorado State Facilitator Project
______ Colorado Retired Teachers Association
______ Teachers Organizations
______ Foresters
______ Grange

Aiken, et. al. (1975) identify four key elements requiring coordination in a fully integrated service delivery system: 1) Clients, 2) Programs and services, 3) Resources, and 4) Information. In order to be able to make decisions about where cooperative efforts need to be undertaken in these areas, the coalition needs to examine data on: Who are the children being served? Not being served? What programs and services are being offered to young handicapped children? What resources are available to young handicapped children and their families? Where are there gaps in services and deficient resources? How are programs, services, and resources funded? What interagency efforts already exist? What are the variations in eligibility requirements? Cost? Staff limitations?

CLIENTS

First, who are the young handicapped children receiving services? An analysis of the numbers of children being served in each age group, birth to three, and three to six is needed. In addition it is important to determine what handicaps are being served. Perhaps there are many programs for young mentally retarded children but very few for the deaf. Also, the degree of severity of the handicapped children being served has to be ascertained. Severely involved children may be receiving the majority of services to the exclusion of the mildly involved children. By examining this data, areas of overlap in services to particular target groups can be found. Gaps in services to an age level, type of handicap or severity level can also be readily seen (see form page 133).

PROGRAMS AND SERVICES

Analysis of the programs and services offered by various agencies and organizations will reveal further duplication and gaps. Requesting information about whether or not an agency provides a specific service directly, purchases the service or doesn't provide the service, but perceives a need for it is important. Such data can not only facilitate development of interagency agreements, but also can assist in planning for future development of the service delivery system. Kazuk, Green and Magrab (1979) discuss a system for analyzing the community resources. The following is a modification of their list of possible services which should be explored within each agency:

-Screening
-Diagnosis
-Specific Discipline Evaluation (e.g., speech & language)
-Multidisciplinary Evaluation
-I.E.P. in PL 94-142
-Comprehensive Individualized Planning
-Counseling Parents
-Special Education (classroom or homebased)
-Regular Education
-Mainstreaming
-Consultation
-Follow-up
-Referral
-Speech Therapy
-Language Therpay
-Physical Therapy
-Occupational Therapy
-Psychiatric Therapy
-Pschological Service
-Nursing Service
-Pediatric Service
-Vision Specialist
-Mobility Training
-Nutrition Consultation
-Case Management
-Parent Education
-Legal (Protective/advocate)
-Recreation Services
-Residential Services
-Respite Care
-Foster Care
-Day Care
-Transportation
-Homemakers Service
-Home Nursing
-Preventive Services
-Public Education
-Staff Training
-Financial Assistance
-Equipment
-Instructional Materials

The accumulation of information about each of these service and resource areas can provide eye-opening awareness of overlap, duplication, and gaps. Again this information can be helpful for both the immediate development of interagency agreements, but also is critical for sagacious future planning (See form pages 133-135 for gathering data).

INFORMATION

Information concerning how programs are funded is particularly relevant to interagency planning. By using funding sources in different ways or paying for services from various federal programs, the number of services which can be made available to young handicapped children can be greatly increased. "It is clear that existing resources beyond those now utilized in special education can be coordinated with other federal programs to benefit children with handicaps" (Audette, 1978, p. 2).

Thus, in making decisions concerning first dollar agreements, the source of funding and eligibility for services is critical. Information relating to available personnel, facilities, equipment and materials is all necessary.

ACCUMULATING DATA

In order to gather data relating to the above areas a relatively simple procedure needs to be developed. Staff from the various agencies already spend much time in filling out forms. They do not want to have to put a lot of effort into an outside agency's request for information. For this reason, it is essential that representatives from as many agencies as possible be involved. In the initial planning process, each representative will need to convince the staff of the benefits of cooperation.

A sample format on how to gather the necessary data is offered here. This procedure can be modified to meet individual community needs. An effort has been made to keep the forms simple and the tabulation process quick.

THE DATA COLLECTION PROCESS

The following discussion will focus on a five-step process which utilizes five sequential recording forms to coordinate community resources for young handicapped children and their families. A complete set of forms can be found at the end of the chapter (pages 131-140).

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Form 1. Target Population Form is designed to determine the number, type and degree of handicapping conditions currently being served.

Form 2. Services Provided/Needed assesses which of forty services are provided by an agency either directly or through purchase of service. It also seeks information on services which are needed.

Form 3. Program Funding Source allows agencies to indicate the primary source(s) of funding for various services which their agency offers.

Form 4. Service Delivery Barriers indicates the problems which agencies are encountering which may be hindering their ability to fully deliver effective and efficient services.

Form 5. Summary of Population and Services is used to summarize data and determine overlaps in age, severity, handicap or services. It also summarizes services which are needed by either agency, services needed by the agency which the school provides, and services provided by the agency which the school district needs.

The coordinating agency (the public school) completes a Community Resources Packet first. Packets are then taken to other participating agencies to be completed. Comparison and analysis follows. The following steps delineate the process in further depth.

STEP 1. The Community Resources Packet (page 133-142) is completed first by the public school early intervention program representative. The facilitating agency in this case is presumed to be the public school, however it could be any agency selected for the role. The shaded columns are filled in by the facilitating agency.

a) Target Population (Form 1) On this form - the shaded boxes are filled in by the facilitating agency (Public Schools) with the number of children currently being served by age; birth to two, two to three, and three to five, under the headings of mildly, moderately, or severely handicapped. This is repeated by category of handicapping condition, indicating the primary diagnosis. Although data may be collected noncategorically, an effort should be made to provide a nonduplicated count by primary handicapping condition.

For example, the public school may be serving 10 moderately handicapped and 20 severely handicapped children birth to two years old, etc. Of those, 2 are blind or visually impaired, 5 are orthopedically handicapped, 13 are mentally retarded, 5 are severely disturbed and 5 are language impaired. This is an unduplicated count by parimary handicap.

Example:
Form 1

Age Range	Mildly Handicapped (mi.)	Moderately Handicapped (me.)	Severely Handicapped (se.)	Blind/Visually Impaired	Deaf/Hard of Hearing	Orthopedically Handicapped	Health Impaired	Mentally Retarded	Severely Disturbed	Learning Disabled	Language Impaired
Birth to 2 yrs.											
2 to 3 yrs.											
3 to 5 yrs.											

b) Services Provided/Needed (Form 2) The second form, Services Provided/ Needed, is completed in a similar way. The shaded column is filled in by the facilitating agency (in this case the Public Schools). If a particular service is purchased by your agency from another agency, check that column. If a service is provided directly by your agency that column is checked. If a service is not provided or is needed the respective boxes are checked.

Example: Form 2

	Purchase of Service	Direct Service	Do Not Provide Service	Need for Service	
(S) Screening	▨	▨	▨	▨	
(SDE) Specific Discipline Evaluation	✓	▨	▨	▨	need Physical Therapist
(MDE) Multidisciplinary Evaluation	▨	▨	▨	▨	

c) Program Funding Source (Form 3) This form is designed to gather information concerning the funding sources utilized to pay for services. This data will be most helpful when interagency agreements are formed, as flexibility in this area will allow for restructuring of payment for services. The facilitating agency again places a check in the shaded boxes to indicate which funding source is being used to pay for particular services. No check is placed where a service is not provided.

For example, if funds from P.L. 94-194 are being used to pay for screening, evaluation, and the development of the individualized education plans, then checks are placed in those respective boxes. Counseling is provided for parents of young handicapped children and is paid for by funds through P.L. 94-194.

Example: Form 3

Funding Program	(S) (1) Screening	(SDE) Special disciplinary Evaluation (2)	(MDE) Multi-disciplinary Evaluation (3)	(IEP) Individual Education plan (4)	(IPP) Individual program plan (5)	(CP) Counseling parents (6)
P.L. 94-194	▨	▨	▨	▨	▨	✓
Title XIX	▨	▨	▨	▨	▨	▨
Title I	▨	▨	▨	▨	▨	▨
Medicaid	▨	▨	▨	▨	▨	▨

d) Problems - Service Delivery Barriers (Form 4)

Information from this form serves many purposes. It allows agencies an opportunity to relate their concerns about shortages of staff, money, facilities, etc. to each other. It also provides a means by which to compare problem areas and, hopefully, work out interagency agreements to solve some of the problems. (This form may also be used as an initial discussion base, to aid program staff in identifying mutual problems and concerns.) The form is filled out by placing a check in the boxes which indicate problems which inhibit the most effective performance of a particular service.

Example:
Form 4

	Insufficient money to pay for service	Insufficient staff to provide comprehensive service	Insufficient materials & equipment	Lack of appropriate facilities	Lack of responsiveness from community resources	Time lag between when service is needed and when it is delivered	Lack knowledge about how to perform service
(S)Screening (1)							
(SDE)Specific Discipline Evaluation (2)							
(MDE) Multidiciplinary Evaluation (3)							

In this example, the school district has had difficulty organizing a Child Find effort, because of lack of knowledge around utilizing community resources to provide comprehensive screening services. They have also had a time lag between referral for evaluation and the actual performance of the evaluation, mostly as a result of a shortage of support staff to be able to do all the needed evaluations.

STEP 2. Make a transparency of all your completed forms for the school district. These transparencies will be utilized for making response comparisons between the public school early intervention program and the other community agencies.

STEP 3. Take a Community Resources Packet to the other agencies or coalition of community resources for young handicapped children. Carefully explain to them the procedure for filling out the forms and how the information will be utilized in developing cooperative efforts to benefit the agencies in their delivery of services to children and their families. Emphasis should be placed on the agencies filling in their response in the unshaded boxes.

STEP 4. Have the agency respresentatives take the forms back to their agencies and meet with their staffs. Each person should explain this process to the staff and enlist their help and support in providing information to complete the forms. This is an important step, as inadequate explanation to the staff can affect the later implementation of ensuing agreements (Smith, 1978).

STEP 5. Collection and analysis of the data gathered takes place as the cooperating agencies return their forms to the facilitating agency. The analysis of the data takes place in the following manner.

First, the transparency of the forms from the facilitating agency are laid directly on top of the first page of the second agencies forms. The agency's name is written in the left hand column of the Summary of Population and Services (Form 5) (See page 142).

The responses from each agency then are compared. The school's responses should appear in the shaded column and the second agency's responses should appear in the unshaded column.

Example: Form 1	Mildly Handicapped (Mi)	Moderate Handicapped(Mo)	Severely Handicapped(Se)	Blind/Visual (Vi)	Deaf/Hearing Impaired(D)	Orthopedic (O)	Health Impaired (H.I.)	Mentally Retarded (MR)	Severely Disturbed (SED)	Learning Disability (LD)	Language Impaired (LI)
Birth to two											
Two to three											
Three to five	10							3			7

It can be seen that there is no duplication in the birth to two or two to three category. There is an overlap in the three to five age range, both in the severity level served (mildly handicapped) and in the handicapping conditions served (mentally retarded and language impaired). From Target Population (Form 1) any duplication of ages, severity levels, or handicaps served should be transferred to the appropriate column on the Summary of Population and Services (Form 5). Put the age range and the initials for the level and handicap (Mi, Mo, Se, M.R., E.D., etc.) in the box on the matrix on Form 5 where there is an overlap.

Example, Form 5

	Age served overlap	Severity level overlap	Handicap overlap	
1. Maple Headstart	3-5	Mi	M.R.	
			L.I.	
2.				

No conclusions are drawn from this data at this time. Discussion of the implications of overlaps will take place later with the agencies concerned. The Services Provided by Each Agency (Form 2) are compared in the same way. A section of one agency's form compared with the school district transparency might look like this:

Example: Form 6

	Purchase of service	Direct Service	Do not provide service	Need for service	COMMENTS
(C) Consultation (11)				✓	need consultation on specific language problems
(F) Follow-up (12)		✓			limited
(P) Referral (13)		✓			
(SI) Speech therapy (14)			✓	✓	

When transferred to the Summary Population and Services (Form 5), the information would appear on the form as follows:

Example: Form 7	Write in initials of services duplicated	Write in initials of needed services by either agency	Write in initials of services the agency purchases that the school could provide	Write in initials of services the school needs that the agency provides
1. Maple Headstart	(F), (R)	(C) (ST)		

As can be seen from the Summary Form, follow-up and referral are two duplicated services. Consultation and speech therapy are two services which the Headstart needs which the school can provide. Again, no conclusions are drawn from this information. But, this will be one topic for discussion with this agency.

It should be noted that these forms can be utilized by any two agencies. A transparency can be made of any one set of forms to be compared to any other set. In the previously discussed example, the public school early intervention program, as a result of the legal mandates of P.L. 94-142, is the agency acting as the service coordinator. Other agencies could also utilize this process to meet the needs of individual children or groups of children. Although designed for coordination of early intervention programs, the forms and procedures can also be used in examining services to older children.

At first glance this process may seem extremely complicated and time consuming. In fact, the reader may at this time be left gasping for breath, thinking that this is one procedure that can surely be skipped. However, interagency coordination is critically important to maximum service efficiency and effectiveness.

The process delineated herein can be useful for:

1) Determining community needs prior to requesting funding, support or writing a grant proposal.
2) Raising the community and legislative awareness level concerning duplication and gaps in services.
3) Solving problems related to needed services for individual children.
4) Evaluating the program's impact on the community service system.
5) Evaluating the effect of coordination on individual children and their families.

A Case Study

Perhaps the best way to demonstrate the usefulness of the process just described is to examine the case of Paul M.. Paul is a four year old, severely handicapped child with Down's Syndrome. He has been in the institution for two years, but has recently been assigned to a foster family in the local community. Paul was referred to Child Find for a complete evaluation. After gathering background information on Paul, representatives from the insitution and social services were included on the evaluation team.

A complete assessment of Paul was done utilizing a multidisciplinary team. The results of that assessment revealed the following needs:

1) need for cognitive activities to stimulate imitation, problem-solving, discrimination and basic classification concepts;

2) need for early language activities to stimulate imitation and production of sounds, recognition of objects and communicative intent;

3) need for motor activities to strengthen muscle tone, develop bilateral coordination, and encourage locomotion;

4) need for social interaction with developmental-age peers to develop onlooker behaviors and beginning social exchange;

5) need for development of attachment to foster parents and development of trusting relationship with adults;

6) need for glasses to correct vision;

7) need for follow-up of medical problems related to heart condition and respiratory problems;

8) need for hearing aid to correct hearing loss;

9) need for training of foster parents concerning care and education of Paul;

10) need for appropriate day care when not in program, as both foster parents work.

It was apparent that the school district would not be able to meet all of Paul's needs. Yet, all aspects were important to effectively serve Paul and his family. In fact, it became clear that support services were essential if the foster care arrangement were to work out. Consequently, the analysis of community resources revealed the following:

1) Paul was eligible to have glasses and hearing aid paid for by Title XIX or Title V.

2) A special morning preschool program which focused on cognitive, language, motor and social emotional development was available in the school district and could be paid for by monies through P.L. 94-142.

3) Physical therapy services, not available through the school could be purchased through Medicaid.

4) Training for foster parents was available through social services, Title XX monies. The parents were also put in touch with Parents Encouraging Parents (PEP) through the Department of Education and with the local Association for Retarded Citizens (ARC).

5) Therapeutic day care services were identified for the afternoons.

Funds from Sentate Bill 26, through Social Services were used to help with funding.

In summary, several points need to be noted. The interagency coordination process is a dynamic process, which demands agency commitment to work effectively. The school districts, as the one agency with whom all children must relate until adulthood, are the logical coordinating agency. Beginning with a coordinated effort from the first referral of a child is important. All agencies previously associated with the child and his/her family should be involved in the evaluation and staffing of the child. Agreements developed may be informal or formal; child specific or program related; directed at standards, resources, or information. Regardless of the nature of the agreements, interagency cooperation and coordination must be viewed as a vitally important process. School districts can and should play a critical role in initiating and implementing effective planning procedures.

COMMUNITY RESOURCES PACKET
FOR
YOUNG HANDICAPPED CHILDREN AND THEIR FAMILIES

Agency ______________________________

Address ______________________________

Contract Person ______________________________

Phone ______________________________

Note: Please fill out in pencil

TARTET POPULATION

Please fill in each white box with the number of children served for each age range and category of handicapped condition. Indicate only one handicap per child, the primary diagnosed handicap.

	Mild Handicap (Mi)	Moderate Handicap (Mo)	Severe Handicap (Se)	Blind or Visually Impaired (B/Vi)	Deaf or Hearing (D/H)	Orthopedic Handicap (O.H.)	Health Impaired (HI)	Mentally Retarded (MR)	Emotionally Disturbed (ED)	Learning Disabled (LD)	Language Impaired (LI)	Multiply Handicapped (MR)
Birth to two years (0-2)												
Two to three years (2-3)												
Three to five years (3-5)												

MAJOR SERVICE AREAS in relation to birth to five population

On the following page please check those services that your agency provides. Check in the purchase service column if your agency purchases service from another agency. Check the direct service column if your agency provides that service at your facility. Check don't provide if the service is not available through your agency. Check need service if that is a service that your agency could utilize.

Form 2

SERVICES PROVIDED/NEEDED

		Purchase of Service	Direct Service	Do Not Provide Services	Need for Service	Comment In the space below elaborate on specific factors of importance in relationship to that service.
(S) Screening	1					
(SDE) Specific Discipline Evaluation (e.g. speech & language)	2					
(MDE) Multidisciplinary Evaluation	3					
(IEP) Individual Educational Plan	4					
(IPP) Individualized Program Plan	5					
(CP) Counseling Parents	6					
(RE) Regular Education	7					
(SE) Special Education	8					
(M) Mainstreaming	9					
(C) Consultation	10					
(F) Follow-up	11					
(R) Referral	12					
(ST) Speech Therapy	13					
(LT) Language Therapy	14					
(PT) Physical Therapy	15					

Form 2

SERVICES PROVIDED/NEEDED

			Purchase of Service	Direct Service	Do Not Provide Services	Need for Service	Comment In the space below elaborate on specific factors of importance in relationship to that service.
(OT)	Occupational Therapy	16					
(PTT)	Psychiatric Therapy	17					
(PGT)	Psychological Service	18					
(N)	Nursing Service	19					
(PED)	Pediatric Service	20					
(VS)	Vision Training	21					
(MT)	Mobility Training	22					
(NU)	Nutrition Consultation	23					
(CM)	Case Management	24					
(PAR)	Parent Education	25					
(RE)	Recreation	26					
(L)	Legal (Protective/advocate)	27					
(RS)	Residential Services	28					
(RC)	Respite Care	30					
(FC)	Foster Care	31					

Form 2

SERVICES PROVIDED/NEEDED

			Purchase of Service	Direct Service	Do Not Provide Services	Need for Service	Comment In the space below elaborate on specific factors of importance in relationship to that service.
(DC)	Day Care	32					
(T)	Transportation	33					
(HS)	Homemakers Service	34					
(HN)	Home Nursing	34					
(PS)	Preventive Services	35					
(PE)	Public Education	36					
(SFT)	Staff Training	37					
(FA)	Financial Assistance	40					
(E)	Equipment	41					
(IM)	Instructional Materials	42					
	Others:						

Form 3

PROGRAM FUNDING SOURCE

Place a check (✓) in the appropriate box to indicate which state or federal soucre(s) supplies funding for the service. More than one source may be checked if appropriate.

FUNDING PROGRAM	(S) Screening	(SDE) Specific Discipline Evaluation	(MDE) Multidisciplinary Evaluation	(IEP) Individualized Educational Plan	(IPP) Individualized Program Plan	(CP) Counseling Parents	(RE) Regular Education	(SE) Special Education	(M) Mainstreaming	(C) Consultation	(F) Follow-up	(R) Referral	(ST) Speech Therapy	(LT) Language Therapy	(PT) Physical Therapy	(OT) Occupational Therapy	(PTT) Psychiatric Therapy	(PGT) Psychological Service	(N) Nursing Service
P.L. 94-142																			
Title I, Disadvantaged																			
Title I, 89-313																			
Bilingual																			
Title XIX, Medicaid, EPSDT																			
Title XX																			
Title V, Maternal Child Health																			
Crippled Children's Program																			
SSI																			
Title V of the Economic Opportunity Act (Headstart)																			
State funding - Developmental Disabilities																			
" " Exceptional Children's Education Act																			
" " Mental Health																			
Other - Please list																			

Form 3

PROGRAM FUNDING SOURCE

Place a check (✓) in the appropriate box to indicate which state or federal soucre(s) supplies funding for the service. More than one source may be checked if appropriate.

FUNDING PROGRAM	(PED) Pediatric Service	(VS) Vision Training	(MT) Mobility Training	(NU) Nutrition Consultation	(CM) Case Management	(PAR) Parent Education	(RE) Recreation	(L) Legal (Protective/ advocate)	(RS) Residential Services	(RC) Respite Care	(FC) Foster Care	(DC) Day Care	(T) Transportation	(HS) Homemakers Service	(HN) Home Nursing	(PS) Preventive Services	(PE) Public Education	(SFT) Staff Training	(FA) Financial Assistance
P.L. 94-142																			
Title I, Disadvantaged																			
Title I, 89-313																			
Bilingual																			
Title XIX, Medicaid, EPSDT																			
Title XX																			
Title V, Maternal Child Health																			
Crippled Children's Program																			
SSI																			
Title V of the Economic Opportunity Act (Headstart)																			
State funding - Developmental Disabilities																			
" " Exceptional Children's Education Act																			
" " Mental Health																			
Other - Please list																			

Form 3

PROGRAM FUNDING SOURCE

Place a check (✓) in the appropriate box to indicate which state or federal soucre(s) supplies funding for the service. More than one source may be checked if appropriate.

FUNDING PROGRAM	(E) Equipment	(IM) Instructional Materials	Other:																
P.L. 94-142																			
Title I, Disadvantaged																			
Title I, 89-313																			
Bilingual																			
Title XIX, Medicaid, EPSDT																			
Title XX																			
Title V, Maternal Child Health																			
Crippled Children's Program																			
SSI																			
Title V of the Economic Opportunity Act (Headstart)																			
State funding - Developmental Disabilities																			
" " Exceptional Children's Education Act																			
" " Mental Health																			
Other - Please list																			

Form 4

SERVICE DELIVERY BARRIERS

PROBLEMS

This is an opportunity for you to get it all "off your chest"! Put checks ( ) in the boxes which indicate why you have a problem with a particular service.

		Insufficient money to pay for service	Insufficient staff to provide comprehensive service	Insufficient materials & equipment	Lack appropriate facilities	Lack of responsiveness from community resources	Hesitancy on part of staff to provide service	Time lag between when service is needed & when it is delivered	Lack knowledge about how to provide this service adequately	Lack of parent cooperation	Lack of facilitative legislation	Prohibition by regulation	Unavailability of qualified staff
(S) Screening	1												
(SDE) Specific Discipline Evaluation	2												
(MDE) Multidisciplinary Evaluation	3												
(IEP) Individualized Educational Plan	4												
(IPP) Individualized Program Plan	5												
(CP) Counseling Parents	6												
(RE) Regular Education	7												
(SE) Special Education	8												
(M) Mainstreaming	9												
(C) Consultation	10												
(F) Follow-up	11												
(R) Referral	12												
(ST) Speech Therapy	13												
(LT) Language Therapy	14												
(PT) Physical Therapy	15												
(OT) Occupational Therapy	16												
(PTT) Psychiatric Therapy	17												
(PGT) Psychological Service	18												
(N) Nursing Service	19												
(PED) Pediatric Service	20												
(VS) Vision Training	21												
(MT) Mobility Training	22												
(NU) Nutrition Consultation	23												
(CM) Case Management	24												
(PAR) Parent Education	25												

Form 4

SERVICE DELIVERY BARRIERS

PROBLEMS

This is an opportunity for you to get it all "off your chest"! Put checks ( ) in the boxes which indicate why you have a problem with a particular service.

		Insufficient money to pay for service	Insufficient staff to provide comprehensive service	Insufficient materials & equipment	Lack appropriate facilities	Lack of responsiveness from community resources	Hesitancy on part of staff to provide service	Time lag between when service is needed & when it is delivered	Lack knowledge about how to provide this service adequately	Lack of parent cooperation	Lack of facilitative legislation	Prohibition by regulation	Unavailability of qualified staff
(RE) Recreation	26												
(L) Legal (Protective/advocate)	27												
(RS) Residential Services	28												
(RC) Respite Care	30												
(FC) Foster Care	31												
(DC) Day Care	32												
(T) Transportation	33												
(HS) Homemakers Service	34												
(HN) Home Nursing	34												
(PS) Preventive Services	35												
(PE) Public Education	36												
(SFT) Staff Training	37												
(FA) Financial Assistance	40												
(E) Equipment	41												
(IM) Instructional Materials	42												
Other:													

Form 5

SUMMARY OF POPULATION AND SERVICES FORM

AGENCIES	Age served overlap	Severity overlap	Handicap overlap	Service overlap	Write in initials of services that are duplicated	Write in initials of services needed by either agency	Write in initials of services the agency purchases that the school could provide	Write in services the agency offers that the school needs
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								

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Kazuk, E., Green, L. and Magrab, P.R., Case study for planning coordinated services. In P.R. Magrab and J.O. Elder (Eds.), Planning for services to handicapped persons: community, education and health. Baltimore, MD: Paul H. Brookes, 1979.

National Association of State Directors of Special Education (NASDE) Publication in press.

Pollard, A., Hall, H. and Keeran, C., Community service planning. In P.R. Magrab and J.O. Elder (Eds.), Planning for services to handicapped persons: community, education, health. Baltimore, MD: Paul H. Brookes, 1979.

FIVE

SCREENING AND ASSESSMENT

Chapter 1 identified the rationale behind early identification and intervention. Clearly, finding and serving handicapped children and their families at the earliest age possible provides benefits to the child, the family and society.

What is the public school's role in locating handicapped children in order that they might receive early intervention? Child Find, the location of handicapped persons birth through 21 years old, is a mandate to all public schools utilizing funding authorized through P.L. 94-142.

"Child find is an active, ongoing process of locating, identifying, and evaluating handicapped children so they may receive a free, appropriate education" (Chazdon, Harvey, McNulty, 1978, p.1). The reader is referred to Child Find, A Handbook for Implementation developed by the Colorado Department of education for detailed guidelines in establishing a Child Find program.

SCREENING

Public schools have a role in identifying handicapped children from birth to five in addition to the school age population through the process of screening. Screening may be defined as "the rapid process of selecting, from the total population of referrals, those students who may have special needs, and/or the process of confirming the need for further assessment". (Recommended Standards and Guidelines to Accompany the Rules for the Administration of the Handicapped Children's Education Act, Colorado Department of Education, Special Education Services Unit 1976).

Screening to determine "special needs" could encompass a great number of medical, psychological, or educational problems. Lillie (1977) offers some guidelines for determining which problems are appropriate for screening and deserve the necessary expenditure of time, money and effort.

1. Screening assumes that the problem being screened for can be ameliorated or modified as a result of subsequent educational treatment programs.
2. Early intervention must improve the condition more than would intervention at a later date when the problem becomes more obvious.
3. The problem or condition being screened for can be specifically diagnosed through further application of measurement procedures.
4. The necessary follow-up procedures for next steps are presently or potentially available.
5. The problem or condition being screened for is relatively prevalent or, the consequences of not discovering a rare problem or condition are very severe.
6. Measurement procedures to screen appropriately for the problem should be readily available (pages 20-21).

Screening will not only allow children to receive needed services at an earlier age, it will also provide important data to assist schools in long range planning for special services.

The screening process should be planned, coordinated and carried out in cooperation with other community agencies and organizations which provide services to young handicapped children and their families. Screening of the child under five years of age presents a set of problems which are unique to the population and thus necessitate community involvement.

1. The child is usually not in a public school classroom setting.
2. The conditions which may have a later effect on learning may be health related and thus necessitate input from health professionals.
3. Certain high risk populations (e.g., abused and neglected children) may best be located through agencies in contact with these families.
4. The developmental rather than academic, nature of screening young children requires discreetly unique screening procedures.
5. Different screening instruments and procedures may be necessary for infants and preschoolers.

A coordinated community screening effort for the under five population can be of benefit to all agencies concerned and can eliminate duplication of effort.

One of the first steps that needs to be taken is a survey of community resources. Such a survey should determine:

1) what agencies are serving handicapped children and their families;
2) the type and degree of service each agency provides;
3) whether the person, agency or organization will participate in Child Find, and how.

The second step involves developing an interagency steering committee to plan and coordinate screening efforts. A summary of the planning process outline by the Colorado Department of Education Child Find Handbook includes the following:

1. Outline goals of the screening program with the other community agencies involved in the Child Find or the interagency committee.
2. Confirm agency commitment through formal (signed written) agreements or informal (verbal or written) agreements which designate persons responsible for specific responsibilities.
3. Utilize existing screening programs. Discuss and come to mutual agreement on methods and procedures to be used jointly.
4. Define the population to be screened.
   -what geographic location will be covered?
   -what age range will be emphasized?
   -will there be eligibility requirements (for other agencies)?
   -approximately how many children will be screened?
   -will transportation be provided?
   -will day care for siblings be provided?
5. Coordinate community screening and the school screening program to prevent overlap of services and to set up an appropriate referral process.
6. Determine the screening areas to be tested
   -developmental (motor, language, social, self-help, adaptive, cognitive, perceptual)
   -speech and language
   -hearing
   -vision
   -social/emotional
   -health/dental
7. Determine screening instruments to be used. Criteria to consider include:

-reliability

-validity

-standardization

-brevity, ease of administration

-cost efficiency

8. Establish sites for screening

   -Public Schools

   -Preschools and Day Care Centers

   -Health Care Settings

   -Community Agencies

   -Child's home

9. Arrange dates and times for screening. Consider-

   -a variety of times

   -during school hours

   -screening of infants - between meals and naptimes

10. Publicize all relevant information so other agencies are aware of it.

11. Determine how the community will be notified of the screening. Start planning for a public awareness campaign.

12. Determine what parental permission is required.

    -permission is not needed for mass screening, but it is needed for diagnostic assessment.

13. Plan for the training of acreeners.

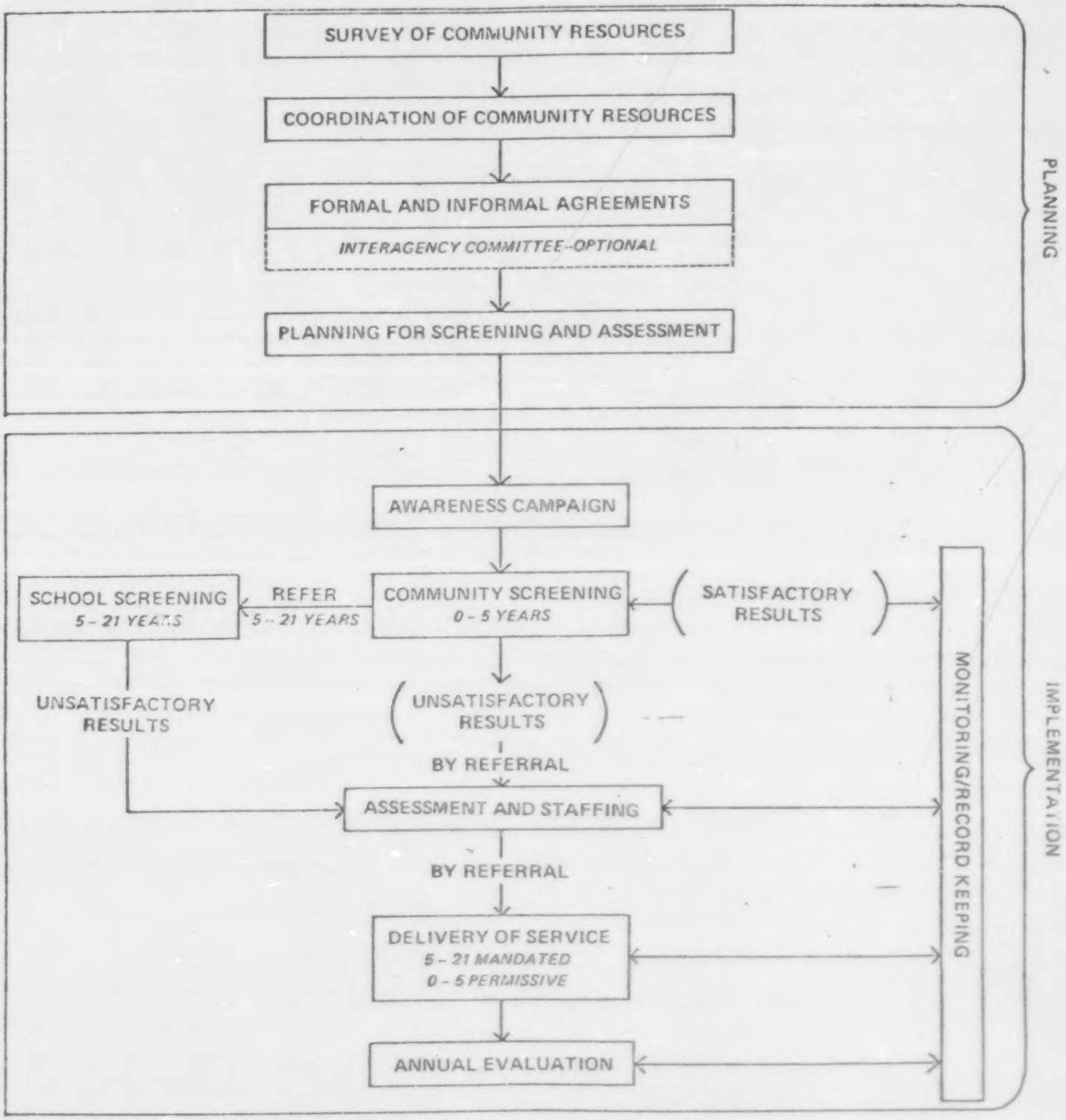
A summary of Colorado's Child Identification model is depicted in Figure 1, page 149 .

SCREENING PROCESS

Depending on procedures and instruments selected by the interagency planning committee, the actual screening process will vary. It is recommended that a

FIGURE 1.

COLORADO'S CHILD IDENTIFICATION MODEL


SURVEY OF COMMUNITY RESOURCES
COORDINATION OF COMMUNITY RESOURCES
FORMAL AND INFORMAL AGREEMENTS
INTERAGENCY COMMITTEE--OPTIONAL
PLANNING FOR SCREENING AND ASSESSMENT
PLANNING
AWARENESS CAMPAIGN
SCHOOL SCREENING
5 - 21 YEARS
REFER
5 - 21 YEARS
COMMUNITY SCREENING
0 - 5 YEARS
SATISFACTORY RESULTS
UNSATISFACTORY RESULTS
UNSATISFACTORY RESULTS
BY REFERRAL
ASSESSMENT AND STAFFING
BY REFERRAL
DELIVERY OF SERVICE
5 - 21 MANDATED
0 - 5 PERMISSIVE
ANNUAL EVALUATION
MONITORING/RECORD KEEPING
IMPLEMENTATION

multidisciplinary team be used. Professionals representing specific disciplines particularly for specific areas of screening such as speech and language, can make valuable clinical observations of the child during screening. However, paraprofessionals can be trained to do most aspects of screening quite effectively.

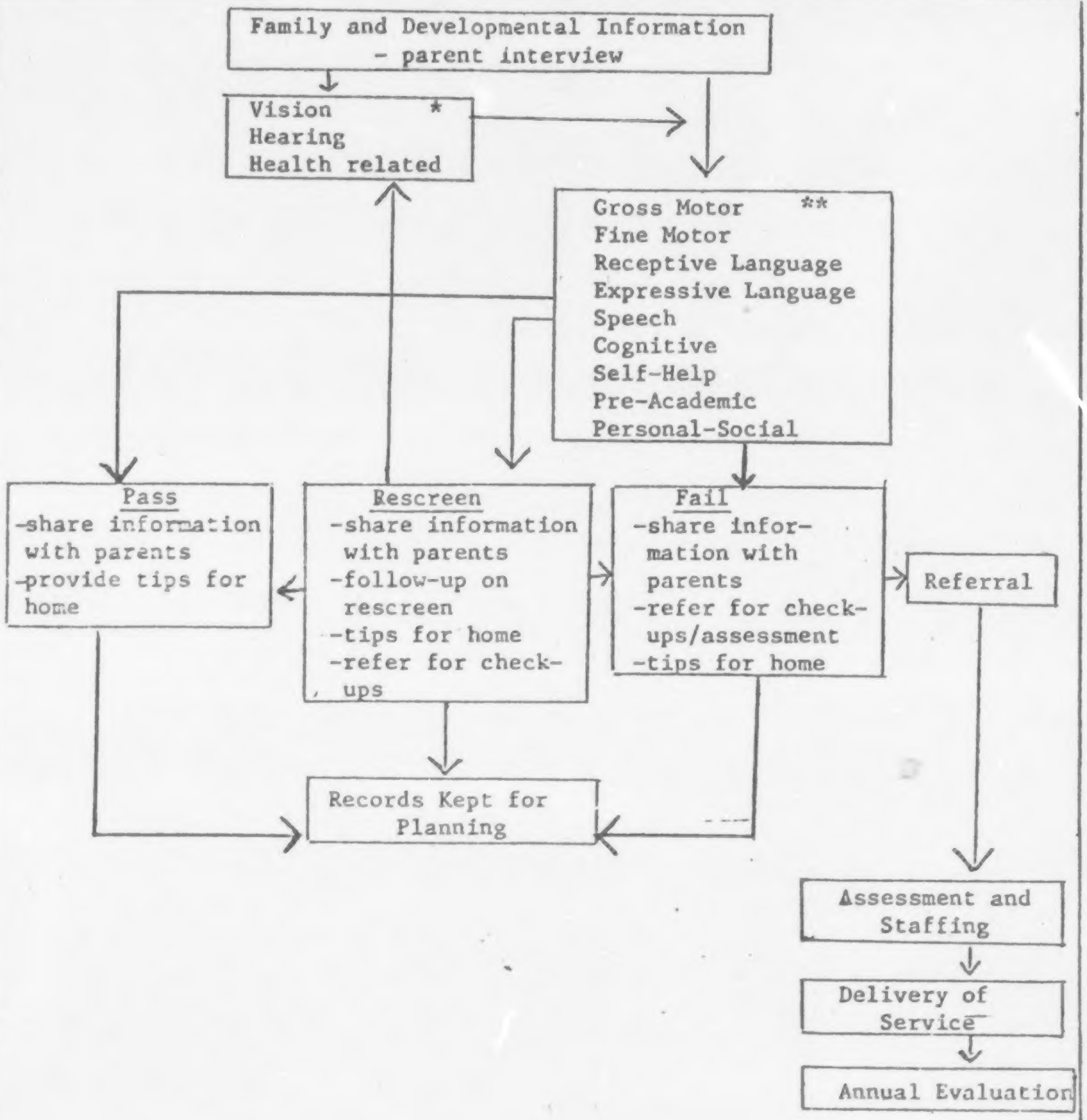
The major components of the screening process are outlined in Figure 2, page 151. The basic elements which need to be included in any screening include:

1) Obtaining family, medical, and developmental information from parents. This includes information on difficulties the child may have had during pregnancy, delivery, post-natally or in the early years. Any concerns the parents may have about the child's development are noted. Information on medical or health related problems is also taken.
2) Vision, hearing or health related screening may be done by appropriate volunteers or agency staff, depending on the goals of screening.
3) Developmental screening is conducted. Screening instruments vary in the developmental areas which they address. Usually the major components include fine and gross motor (and/or self-help), expressive and receptive language (often including a speech section), and cognitive or adaptive reasoning. Often a section is included which examines behavior relating to social-emotional development. Some instruments geared for kindergarteners look at pre-academic skills as well.

   In determining the processes and procedures for screening, care should be taken to avoid "over-identifying" or "under-identifying". That is, identifying children who really are not handicapped or missing those who are handicapped and in need of service. Careful selection of instruments, and development of local criteria for pass-fail cutoff is thus very important.

FIGURE 2.

SCREENING PROCESS


Family and Developmental Information - parent interview
Vision *
Hearing
Health related
Gross Motor **
Fine Motor
Receptive Language
Expressive Language
Speech
Cognitive
Self-Help
Pre-Academic
Personal-Social
Pass
-share information with parents
-provide tips for home
Rescreen
-share information with parents
-follow-up on rescreen
-tips for home
-refer for check-ups
Fail
-share information with parents
-refer for check-ups/assessment
-tips for home
Referral
Records Kept for Planning
Assessment and Staffing
Delivery of Service
Annual Evaluation

* optional depending on interagency screening plans.
** depending on instruments chosen

4) Determination of status. Another means of avoiding the problem of over or under-identification is to develop a review system. Children who obviously pass do not need to be discussed. Children who have failed several sections of the screening are automatically referred for further evaluation. It is the "questionable" group of children who deserve to be discussed. Data from the screening can be discussed by the team and determination can be made as to whether the child should be rescreened in one or more areas or should be referred for an in depth evaluation of one or more areas. Rescreening is advised over "passing" a child who has performed "questionably".

5) Sharing results. Parents of all children should have the results of the screening interpreted for them, along with a re-explanation of the purpose of screening. Regardless of whether the child "passed" or "failed" the screening, the parents should be informed that a screening looks only at a few selected behaviors. A "fail" does not constitute a confirmation of a problem or a diagnosis, just as a "pass" does not insure a problem-free future. Parents should also be advised if any further check-ups are needed. Also, activities or suggestions for home are often welcomed by parents. If the child is being referred for further evaluation, a personal interview with the parents is important to explain the procedures which will take place and to provide support to parents who may feel fearful of the assessment process.

Careful records should be kept on all children going through the screening process as this will provide valuable information to service providers for long-term planning. Issues of confidentiality need to be addressed as part of the interagency planning process. Permission can be obtained from parents for cross-agency sharing of information in accordance with due process procedures.

EVALUATION

Children who have been referred by other agencies (such as social services), by professions (such as doctors or therapists), or by parents, and who have failed the screening are in need of further evaluation. As stated in the Federal Register, December 30, 1976, "evaluation (assessment) means procedures used to determine whether a child is handicapped and the nature and extent of the special education and related services that the child needs. The term means procedures used selectively with an individual child and does not include basic tests administered to or procedures used with all children in school, grade, or class".

Thus, evaluation implies an individual assessment which usually results in a determination or "diagnosis" of a handicapping condition. "Literally, diagnosis means 'knowing thoroughly'. Use of the term diagnosis is taken from the medical model which involves giving examinations and interpreting symptoms in order to find the cause of the disorder and to prescribe treatment. In the field of education, it may refer to the labeling of specific disorders or categories" (Chazon, et.al., 1978, p. 137).

Cross and Goin (1977) describe diagnosis as looking at the child and his environment for four purposes:

1. to determine whether a handicapping condition (or conditions) exist;
2. to clarify the causes of the identified problem (i.e., is the child nonverbal due to a hearing impairment, mental retardation, an information-process problem, or lack of verbal stimulation);
3. to develop a treatment plan;
4. to ascertain the most appropriate service that the program can render the child (p. 7).

Diagnosis involves an in-depth examination of problems which were identified during screening. Whereas screening may be done by trained paraprofessionals, diagnosis must involve professionals from a variety of fields - including medicine, psychology, specific therapies, and education. Whether or not diagnosis, or labeling, is necessary is a controversial subject. It is felt by many to be important to provide an appropriate placement and to justify funding expenditures.

The primary goal of educational diagnosis is to provide information regarding a child's needs. Harbin (1977) defines educational assessment as "the systematic process of 1) collecting information both on a child's level of functioning in specific areas of development and on his learning characteristics and 2) carefully interpreting the information which is collected" (p. 35). The interpretation of this information is used to determine the placement of the child in the least restrictive environment and the "most productive" environment possible (Melcher, 1978). The information is also utilized in developing a comprehensive and specific plan for the child's day-to-day educational program. Ingram (1980) states that another purpose of assessment data is to assist in "outlining the evaluation procedures that are to be used in determining the effectiveness of the child's individual educational program in meeting identified goals and objectives" (p. 5).

In summary, assessment should provide some global information about the child - How does the child compare to other children his/her age? It should also provide educators with specific information for the classroom - what skills is the child ready to learn? Assessment should also give direction to the staff who will be working with the child - In what ways does this child learn most effectively? Figure 3 on page 155 summarizes the global and specific questions that the assessment process should address.

Figure 3.

PURPOSES OF ASSESSMENT

Global for Placement	Specific for Classroom
1. Does a handicap exist? (diagnosis)	1. What are the child's strengths and weaknesses? (profile)
2. What is the etiology of the handicap?	2. What is the treatment for the problems or condition?
3. What is the child's developmental level?	3. What skills does the child need to acquire?
4. What placement is most appropriate and least restrictive?	4. What environment is most appropriate for learning?
5. What services does the child need?	5. a. How does the child learn most effectively?
	b. What skills is the child ready to learn?
6. What services does the family need?	6. What suggestions are there for the family to do at home?
7. How far has the child progressed?	7. How will we know whether our intervention is successful?
8. What follow-up will be provided?	8. What information will follow the child?

TEAM COMPOSITION

Higgins (1977) outlines seven points that should be considered in organizing for evaluation to meet the provisions outline in P.L. 94-142:

1. the public agency responsible for determining that the child has a specific handicap will use a team to evaluate that child;
2. the official from the education agency responsible for the administration of special education programs will be responsible for appointing team members;

3. the composition of the team must include the child's regular teacher or a teacher licensed or certified by the state agency and appointed by the official representing the educational agency completing the assessment;
4. one additional individual certified or licensed by the state education agency to conduct individual diagnostic examinations (school psychologist, speech clinician, or resource teacher) must be included on the assessment team;
5. members constituting the team shall be chosen on the basis of their knowledge of procedures used in the evaluation of children;
6. each individual team member must be qualified to perform the specific assessment tasks they have been assigned; and
7. after the evaluation, the team should meet at least once to discuss the evaluation and to reach a decision as to the child's performance (Ingram, 1980, p. 6-7).

EDUCATIONAL ASSESSMENT PROCESS

The assessment process can be divided into five phases:

Phase I.	Assessment planning
Phase II.	Assessment (analysis)
Phase III.	Interpretation (synthesis)
Phase IV.	Program planning
Phase V.	Classroom assessment

The first four phases are completed by a multidisciplinary team assigned to evaluate the child. The first four phases go up to and include the staffing process which occurs in phase IV. The final phase, classroom assessment, is conducted by those team members working directly with the child after the child has been placed in the appropriate setting.

Each of these phases will be examined in depth in the following discussion. Figure 4, on page 158 provides flow chart illustrating the total process.

Phase I. ASSESSMENT PLANNING

After receiving a referral on a child, planning needs to take place to determine the nature of the assessment which will follow. Whoever is responsible for handling the initial referrals, usually an intake social worker or the program coordinator, needs to review the information which comes with the referral.

Occasionally, more information is needed and the intake person may need to contact the parents, send for medical records, or talk to the child's preschool or day care teacher. Informal observations of the child are advised whenever possible. After gathering the necessary referral information, the intake worker has some idea of the "referral questions" or the reasons for further evaluation. These questions may eminate from the professional screening:

-what are the child's linguistic capabilities?

-at what level is the child functioning cognitively?

-does the child have an identifiable motor handicap?

or the teacher or parent might ask more informal questions such as:

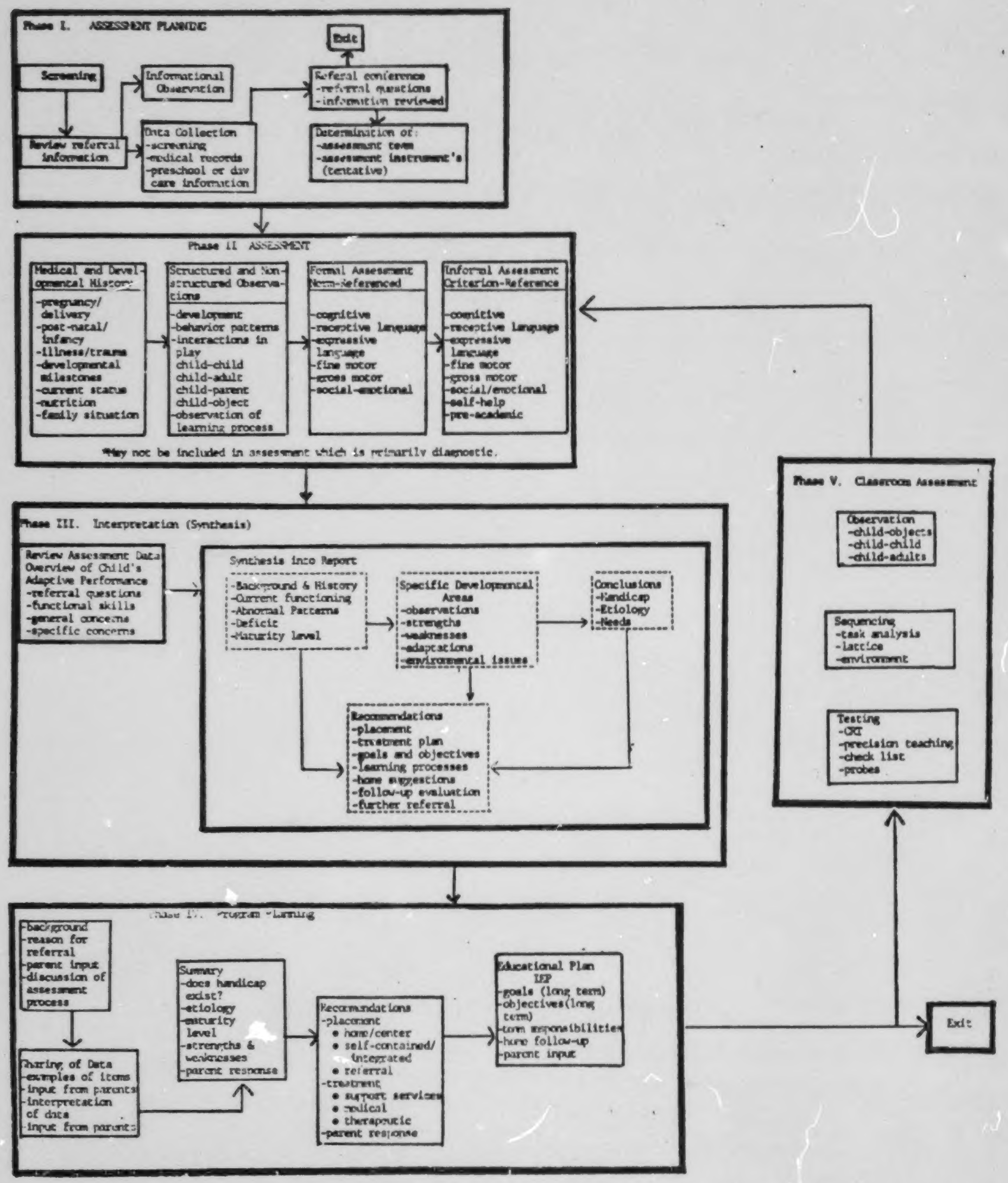
-why doesn't he talk very well?

-why doesn't he pay attention and mind?

The intake person calls referral conferences to review all pertinent information regarding referral questions and to ascertain whether or not any assessment, a full assessment battery, or partial assessment is indicated. The full team should discuss the referral information and make the following decisions:

1. How could the child function better in his/her present environment? (exit, with modification in present placement)
2. What additional information is needed?

Figure 4 THE ASSESSMENT PROCESS

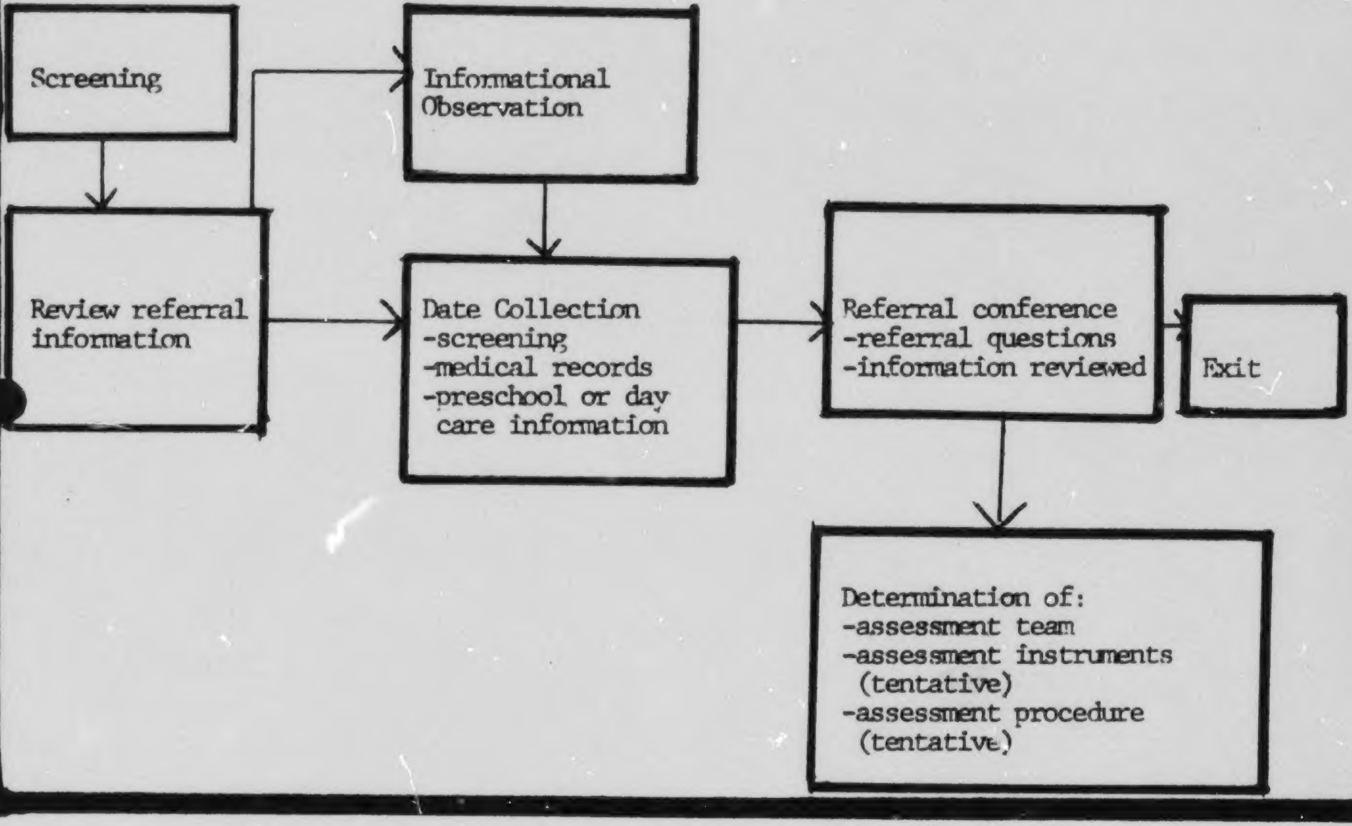

Phase I. ASSESSMENT PLANNING
Screening
Review referral information
Informational Observation
Data Collection
-screening
-medical records
-preschool or day care information
Referral conference
-referral questions
-information reviewed
Exit
Determination of:
-assessment team
-assessment instrument's (tentative)
Phase II ASSESSMENT
Medical and Developmental History
-pregnancy/delivery
-post-natal/infancy
-illness/trauma
-developmental milestones
-current status
-nutrition
-family situation
Structured and Non-structured Observations
-development
-behavior patterns
-interactions in play
child-child
child-adult
child-parent
child-object
-observation of learning process
Formal Assessment Norm-Referenced
-cognitive
-receptive language
-expressive language
-fine motor
-gross motor
-social-emotional
Informal Assessment Criterion-Reference
-cognitive
-receptive language
-expressive language
-fine motor
-gross motor
-social/emotional
-self-help
-pre-academic
*May not be included in assessment which is primarily diagnostic.
Phase III. Interpretation (Synthesis)
Review Assessment Data
Overview of Child's Adaptive Performance
-referral questions
-functional skills
-general concerns
-specific concerns
Synthesis into Report
-Background & History
-Current functioning
-Abnormal Patterns
-Deficit
-Maturity level
Specific Developmental Areas
-observations
-strengths
-weaknesses
-adaptations
-environmental issues
Conclusions
-Handicap
-Etiology
-Needs
Recommendations
-placement
-treatment plan
-goals and objectives
-learning processes
-home suggestions
-follow-up evaluation
-further referral
Phase IV. Program Planning
-background
-reason for referral
-parent input
-discussion of assessment process
Sharing of Data
-examples of items
-input from parents
-interpretation of data
-input from parents
Summary
-does handicap exist?
-etiology
-maturity level
-strengths & weaknesses
-parent response
Recommendations
-placement
• home/center
• self-contained/integrated
• referral
-treatment
• support services
• medical
• therapeutic
-parent response
Educational Plan IEP
-goals (long term)
-objectives (long term)
-team responsibilities
-home follow-up
-parent input
Exit
Phase V. Classroom Assessment
Observation
-child-objects
-child-child
-child-adults
Sequencing
-task analysis
-lattice
-environment
Testing
-CRT
-precision teaching
-check list
-probes

3. Who would be the most appropriate individuals to obtain the needed information?

4. What instruments or procedures would be most appropriate for obtaining the needed information?

Figure 5

Phase I. ASSESSMENT PLANNING


Screening
Informational Observation
Review referral information
Date Collection
-screening
-medical records
-preschool or day care information
Referral conference
-referral questions
-information reviewed
Exit
Determination of:
-assessment team
-assessment instruments (tentative)
-assessment procedure (tentative)

GUIDELINES FOR ASSESSMENT PLANNING

What additional information is needed?

Multidisciplinary evaluation is important to ensure obtaining a complete picture of the child's performance (Cross and Goin, 1977). However, unnecessary evaluation should be avoided. Information which is available from other sources should be used whenever possible.

Who would be the most appropriate individuals to obtain the needed information? Traditionally professionals are trained to perform specific roles and functions.

They are often trained to administer specific types of instruments. For example, social workers are trained to do family interviews, social histories and gather relevant data through interview techniques. Speech and language pathologists in addition to being trained in assessing speech and language skills are also often trained to do feeding assessments, behavioral observations and family interviewing. Administrators need to know the skills of the team and utilize their expertise in the most effective and efficient way. Staff should be qualified to do the testing needed, particularly when using standardized tests.

What instruments or procedures would be the most appropriate for obtaining the needed information? This question is particularly important as there are a great many different instruments available on the market. Some have been around awhile, while many are quite new. Some are highly touted and others are controversial. It is important for staff to keep current on new instruments, but also to be current on the research regarding all instruments. Each instrument should be analyzed to determine:

-validity - has the test been proven to measure what it purports to measure?

-reliability - does the test provide a consistent estimate of behavioral performance?

-standardization - was the test standardized on a sample population with demographic characteristics similar to those of individuals to be tested? Administration and scoring procedures should also be standardized in order that interpretation of test results be as accurate as possible.

-bias - is the test biased or discriminatory against any cultural minority? Is it biased so that a particular handicap (e.g., blind or deaf) will be penalized by standardized administration?

These considerations are particularly important for the global purposes of assessment as outlined in Figure 3 on page 155 . In addition to studying test manuals for the above information, staff should be familiar with O.K.

Buros Mental Measurements Yearbook, and F. Davis, Test Analysis: Screening and Verification Instruments for Preschool Children Department of Education, Commonwealth of Pennsylvania. Diagnosis, developmental level, and placement decisions have tremendous implications for the child and should not be treated lightly. Psychoeducational testing done in Phase II should utilize appropriate instruments for these purposes. In Phase V where classroom assessment takes place, a wider variety of instruments are legitimate. Discussion of the informal, criterion referenced assessment which will be done is also discussed at the assessment planning phase.

Phase II. Assessment (Analysis)

A few guidelines for organization and implementation of the assessment process should be noted.

1) Assessment should be systematic, thorough and accurate.
2) Assessment needs to take place with full due process rights accorded to the child and the family.
3) Assessment should take place in the child's native language.
4) When the child has a known handicap (such as cerebral palsy or visual impairment) the nature of the handicap should be considering during the collection and interpretation of assessment data.
5) A combination of norm-referenced, criterion-referenced, observation and Piagetian devices should be used in assessment.
6) The importance and effect of the environment on the child should be kept in ming during assessment. Everything possible should be done to ensure the child's best performance. (Harbin, 1977, p. 36-39).
7) Rapport with the child is very important. The child needs to feel

comfortable with the environment and the testor before assessment begins

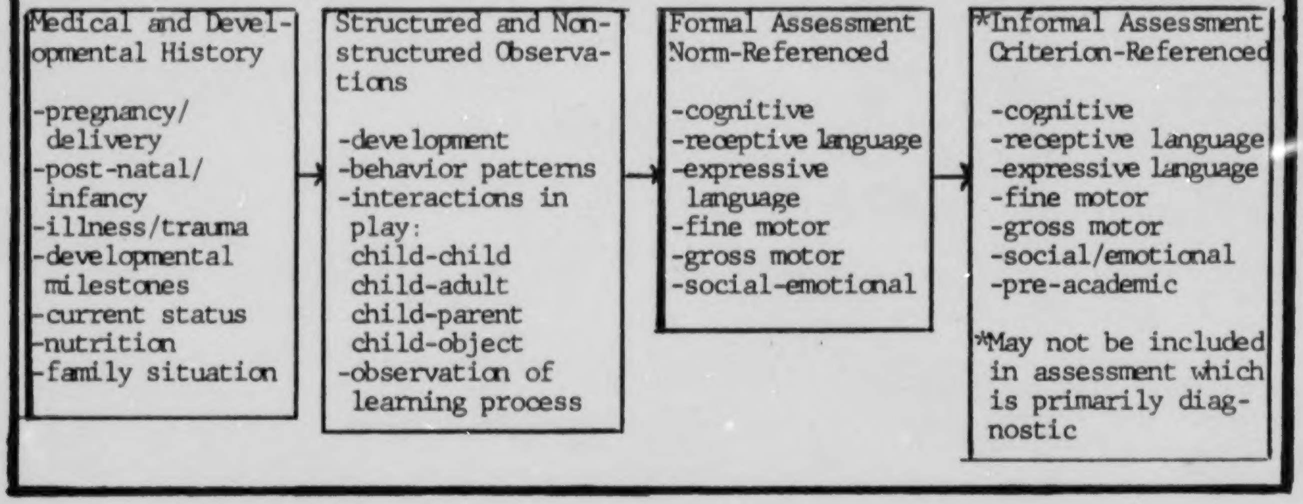
8) Confidentiality needs to be ensured and procedures established for cross-agency information sharing.

Organization of the Process

With various team members carrying out different assessment responsibilities there may be several assessment procedures occurring simultaneously. However, there should be an overall pattern to assessment and a process model which is followed. Figure 6, Phase II, Assessment below delineates the recommended process.

Figure 6

Phase II. ASSESSMENT


Medical and Developmental History
-pregnancy/delivery
-post-natal/infancy
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-developmental milestones
-current status
-nutrition
-family situation
Structured and Non-structured Observations
-development
-behavior patterns
-interactions in play:
child-child
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child-parent
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-observation of learning process
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*Informal Assessment Criterion-Referenced
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-receptive language
-expressive language
-fine motor
-gross motor
-social/emotional
-pre-academic
*May not be included in assessment which is primarily diagnostic

Medical and Developmental History

The medical history is often obtained directly from the child's physician (after permission has been granted by the parents or release of information). However, most agencies have their own intake forms which requests this information from the parents, usually through an interview. Many parents have already "been through" their child's medical and developmental history "umpteen" times. If the information needed is present in the child's medical history, only information which is not currently available in the records should be sought from the parents. It is wise to first determine what experiences the parents have been through with other agencies and what their level of understanding is concerning their child's medical history. Some parents have been greatly shocked and dismayed to learn that a label of cerebral palsy or autism, for example, has been put in their child's medical records without their knowledge. Negative feelings may be avoided if the staff do not assume the knowledge level of parents concerning the problems of their child and the information contained in records.

Information relating to the medical and developmental history of the child may provide clues to the etiology of the child's problems. This "piece of the puzzle" may have implications for treatment (as in the case of epilepsy or endocrinological disorders) or it may provide some help to parents who almost universally desire to know 'why?'. Most medical and developmental history data forms include questions concerning the following: (see Figure 7, p. 164).

-pregnancy. Difficulties the mother may have had including illness, trauma, infection, blood disorders, nervous condition, or other abnormal conditions.

-delivery. Information on the gestational age, birth weight, time of and difficulties in labor are all significant.

-post-natal. The child's Apgar score, difficulties with breathing, blood, jaundice, or physical abnormalities.

-infancy. Illnesses, trauma, seizures and high fevers are examples of information which is sought.

-developmental milestones. Extreme delays or unexpected cessation of expected normal behaviors such as babbling and use of words, sitting,

Figure 7.

AREAS OFTEN COVERED ON GENERAL CASE HISTORY FORMS[1]

1. Birth History
   - Previous pregnacies
   - Miscarriages
   - Mother's health/attitude
   - Labor
   - Delivery
   - Birth Weight
   - Trouble breathing, sucking
   - Jaundice, cyanosis
   - Oxygen
2. Motor Development
   - Sat alone
   - Crawled
   - Fine and gross motor coordination
   - Feeding, sucking, chewing
   - Drooling
   - Toilet training
   - Enuresis
   - Self-help
3. Language
   - Comprehension
   - Gestures
   - Echolalia
   - Perseveration
   - Onset of words
   - Current number of words
   - Onset of sentences
   - Examples of sentences
   - % understood by parents
   - % understood by other adults
   - % understood by siblings
   - % understood by peers
   - Child's awareness of problem
   - Previous assessment
   - Previous training
4. Family
   - Parent's age, health
   - Parent's occupation
   - Parent's education
   - Parent's income
   - Marital status
   - Is child adopted
   - Siblings; age, health
   - Others in home; age, health
   - History of learning problems in family
   - Other problems
   - Language spoken in home
   - Transportation
5. Interpersonal Relationships
   - General disposition
   - Playmates and play habits
   - Parent-child relationships
   - Other adult relationships
   - Incontact with environment
   - Discipline
   - Affectionate
   - Aggressive
   - Compulsive
   - Cries easily
   - Daydreamer
   - Fears
   - Hyperactive
   - Jealousy
   - Leader or follower
   - Perservation
   - Sleep habits
   - Social perception
   - Tantrums
   - Psychological assessment (s)
   - Psychological treatment (s)
   - Psychiatric assessment(s)
   - Psychiatric treatment (s)
6. Medical History
   - Convulsions
   - Fever
   - Childhood diseases
   - Cerebral problem(s)
   - Glandular disturbance
   - Excessive sweating
   - Allergies
   - Drug therapy
   - Auditory problems
   - Vision problems
   - Operation
   - Accidents
   - Congenital defects
   - Name of doctor

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[1] From Cross L. and Goin K. (eds.) Identifying handicapped children, in guide to casefinding, screening, diagnosis, assessment and evaluation, New York, Walker and Company, 1977. p. 30.

crawling, and walking are often indicators to both parents and professionals that there may be a reason for concern.

- nutrition. Difficulty with feeding, unusual eating habits, or poor nutrition may cause problems not only in development but also in parent-child interactions, and is thus an important area for exploration.
- family situation. Although sometimes "touchy" or difficult to discuss the nature of the family situation is important. Patterns of interaction, marital status, stresses, support systems, sibling relationships, extended family relationships all may provide data which may relate to the problem either diagnostically or therapeutically, having implications for the most appropriate means of intervention.

OBSERVATION

The formal testing situation is often highly structured and takes place in an environment which is unnatural to the child. Consequently, the behaviors that are observed under the testing situation might not be indicative of the child's typical behavior patterns. It is, therefore, extremely important to observe the child in a variety of other more natural settings, including home and day care or preschool. Varying the time when the child is observed may also make a difference in the types of and quality of behaviors observed. For example, the child's "best" time might be right after eating or after a nap. Observation can be done by any or all of the team members involved in the assessment of the child. The social worker often makes a home visit to obtain the medical and developmental history. This is a good opportunity to observe the child in his natural environment. The teacher or developmental specialist might also want to observe the child in his/her nursery or preschool program

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STRUCTURED OBSERVATION. There are several types of structured observations which may be used in assessment. One of the most frequently used is a checklist which looks at developmental areas. The following types of questions may be listed with alternative responses to be checked: How does the child move? How does the child communicate? How does the child solve problems? How does the child react to modeling? What types of prompts are most effective? What signals are needed to arouse attention? How does the child react to failure? In observing the child eating, playing, dealing with frustration some inferences can be made about how the child adapts within his various environments. Any differences in performance under differing circumstances should be noted as they may be relevant to program planning.

A second type of structured observation is one which is frequently done with children who exhibit maladaptive or bizarre behaviors. The structured observation consists of observing the child and obtaining baseline data on the frequency, duration and intensity of the behaviors. In addition, the observer watches what happens in the child's environment - actions which precede the behavior on the part of the child and any other person in the room. These are known as "antecedents" to the behavior. The observer also notes what happens to the child and others in the room after the behavior occurs. These are known as "consequences". The observer also notes what is reinforcing or motivating to the child within his environment.

This quantitative data on frequency counts, reinforcers, antecedents and consequences is then used to determine how the behavior can be modified to become more acceptable.

NON-STRUCTURED OBSERVATIONS. Some observers find it useful to observe the child without a checklist or baseline chart. They prefer to take "raw data" - or just write down everything they observe the child doing. This allows for an analysis of the data later with the team. The other team members may thus obtain information on movement, language patterns, etc. with a qualitative description. Raw data or non-structured observations are really structured in the analysis rather than the data taking, as the data should be examined in a systematic manner. Patterns of interaccion are studied between:

- the child and other children
- the child and his/her parents
- the child and other adults
- the child and objects
- the child and events within the environment.

GUIDELINES. Regardless of whether structured or non-structured observations are used, there are general suggestions to be followed:

1. Observe the child in a variety of times and settings.
2. Observe the child at play. Behavior patterns and skills which have become functional will be observed in play, as will problem-solving abilities and motivating factors.
3. Look for patterns of behavior and situations which affect behavior.
4. Look for the child's individual way of learning or processing information.
5. Develop a structure of analysis of observation data.
6. Note how and where the child was observed and the length of the observation.

Information about the child and the family which is gained through observation is a very critical, yet is often an overlooked aspect of assessment. It is often particularly useful in Phase IV, Program Planning. It should be built into the assessment process from the beginning and not added as an after thought whenever it is convenient.

FORMAL ASSESSMENT

Assessment is conducted to measure human capacity, ability, behavior or performance (Ingram, 1980). Formal assessment is the use of norm-referenced or standardized tests. In norm-reference testing, an individual's performance is measured against others of the same age. Salvia and Ysseldyke (1978) point out that in norm-referenced assessment learning of content is important only to the extent that it allows rank-ordering of individuals from those who have acquired a few skills to those who have acquired many. The usefulness of norm-referenced testing, then, lies in its ability to give an overall perspective as to how the child compares to his or her peers. Norm-referenced tests are thus relevant for:

- screening
- to compare a child against regional or national norms
- to make placement decisions
- to evaluate overall progress from year to year

Ingram (1980) characterizes norm-referenced tests as having:

1. specific administration procedures
2. definite scoring criteria
3. distinct methods for interpreting scores which are discussed in full detail. The child's actual performance is obtained from a combination of norm-referenced and criterion-referenced testing.

With the under-five population there are a variety of norm-referenced tests in each of the areas usually measured-

- sensorimotor
- gross motor
- receptive language
- expressive language
- cognition or adaptive reasoning
- social emotional

The reader is referred to Identifying Handicapped Children, A Guide to Casefinding, Screening, Diagnosis and Assessment edited by Lee Cross and Kenneth Goin, 1977, Child Find: A Handbook for Implementation developed by the Colorado Department of Education, 1977, for a description of various instruments.

If a full battery of tests is being done with a child a test which is comprehensive in nature is usually completed first. The Bayley Scales of Infant Development are frequently used with children under two-and-a-half. Information on the child's language, cognition, motor development and behavioral observations are obtained. With preschool-age children the McCarthy Scales of Children's Abilities is popular. The McCarthy provides information on sub-areas in verbal, perceptual, quantitative, memory and gross motor development. Regardless of which test, one of these or other tests, is used the purpose is the same - 1) to gain an overall understanding of where the child is functioning compared to other children of the same age, and 2) to pinpoint strengths and weakness within the child's ability range, 3) to provide direction for further assessment.

It is important to note that the use of such an inclusive test is only the beginning and should never constitute the entirety of assessment data. From the comprehensive overview, team members obtain clues as to further in depth testing which needs to be done. For example, areas of weakness on the Bayley may indicate a need for further cognitive evaluation using the Uzgiris and Hunt Scales (ordinal scales which are not standardized) or after completing the McCarthy more Piagetian testing might be desired (not standardized) to see how the child processes cognitive information. Further testing using other normative tests in sub-areas of speech or linguistic patterns may be advisable. The original testing plans of the team should be seen as tentative. For example, a child may have been set up for psychological and speech and language evaluation; however, the motor sub-tasks of the McCarthy may have indicated some difficulty with bilateral patterns. The occupational therapist or physical therapist can then be added to the assessment team to provide the needed indepth motor evaluation.

Data which is gathered from normative testing needs to be combined with data gathered through observation and through informal assessment processes to provide a total picture of the child. The developmental specialist or teacher's role is important in all of these areas, but particularly in relation to criterion referenced testing.

INFORMAL ASSESSMENT

The purpose of a criterion-referenced devise is to compare the child not to other children but to a set of standards (usually derived from norm-referenced tests). The criterion-referenced test (CRT) allows the teacher to determine the level at which the child is functioning and to measure the child's progress from one point in time to another, not in terms of an overall score but in terms of specific developmental skills.

The advantage of a CRT is that it allows the teacher to construct tests to measure specific skills which may not be evaluated on the norm-referenced tests. Howell, Kaplan and O'Connell (1979), give specific directions for developing CRT's.

1. A decision is made concerning what specific questions need to be answered about a student's behavior. What ability (i.e., skill and/or knowledge) needs to be tested?
2. A performance objective is written which describes how the child will be tested. It includes - a) what the student must do (i.e., what behavior must be engaged in); b) under what conditions the student will engage in this behavior; and c) how well the student must perform in order to pass the test. If the performance objective is complete and comprehensive it will be reliable.
3. The performance objective (which can also be used in the child's program plan) can be used to construct a CRT. The necessary components of a CRT exist in the performance objective. These components are (a) the directions for administering and scoring, (b) the criterion

for passing the test, and (c) the materials and/or test items necessary.

4. Those individuals who are considered to possess the skill measured by the CRT are identified and administered the CRT. The minimum level of their performance is used as the standard for passing the test. This standard is referred to as the criterion for acceptable performance (CAP). The CRT should be consistently administered and scored according to the prespecified directions (p. 97-99).

Howell et.al. (1979) also provides the following example of a CRT and its scoring sheet.

SAMPLE CRITERION-REFERENCED TEST

Task: Names each of the eight basic colors when shown

Materials: One box of crayons (to include eight basic colors). One scoring sheet.

Directions (to student): "Say the name of each crayon as I hold it up You have only three seconds to give me your answer, so pay close attention, (Pick up the first crayon). What color is this?" Repeat procedure for each of the eight colors. Do not tell the subject if she is correct or incorrect. Do not let the student see what you are marking. Use a stopwatch or a sweep second hand out of the subject's field of vision. Timing should begin immediately following the word "this" in the directions.

Scoring: Wait 3 seconds for response. If the response is incorrect, put the crayon back in the box and mark "incorrect" on the scoring sheet. If the response is correct, put the crayon back in the box and mark "correct" on the scoring sheet. If the child hesitates, wait the full 3 seconds before putting the crayon back in the box and mark "incorrect".

SCORING SHEET

Skill: Knowledge of the eight basic colors

Task: Names each of the eight basic colors when shown

Subject ______________________ Age __________

Examiner ______________________ Date __________

Stimulus:	Response: (check one)		
		Correct:	Incorrect:
1. red	1.	______	______
2. blue	2.	______	______
3. yellow	3.	______	______
4. green	4.	______	______
5. black	5.	______	______
6. orange	6.	______	______
7. brown	7.	______	______
8. purple	8.	______	______

Sample Criterion-Referenced Test and Scoring Sheet from Howell, K.W., Kaplan, J.S., and O'Connell, C. Y. Evaluating Exceptional Children, A Task Analysis Approach.

The CRT can be of great use to the assessment team both in determining where and how the child is functioning and also in planning the child's educational program. The development of CRT's takes time, however. Fortunately, a great many criterion-referenced devises are already in existence and the teacher can utilize those which are most relevant to the child being assessed. In addition to the traditional developmental areas assessed by non-referenced tests, the criterion-referenced assessment devises may also contain sub-areas addressing preacademic skills and self-help skills. Additional CRT's can be developed as needed. (Again the reader is referred to the Cross and Goin book for sources of CRT-based assessment instruments).

GUIDELINES

1. Utilize normative data to provide inter-individual comparisons (skill levels of child compared to age peers).
2. Utilize a comprehensive normative test to provide an overview of the child's strengths and weaknesses.
3. Utilize normative assessment to provide direction for further testing.
4. Keep the assessment plan flexible, so that assessments can be added or deleted as necessary.
5. Utilize criterion-referenced data to supplement normative data and to provide intra-individual comparison (specific skill levels of an individual child).
6. Develop new CRT's as needed for individual children.
7. Consider any biases the tests may have when given under standardized conditions, and supplement the assessment with instruments that are designed to show maximum performance levels.

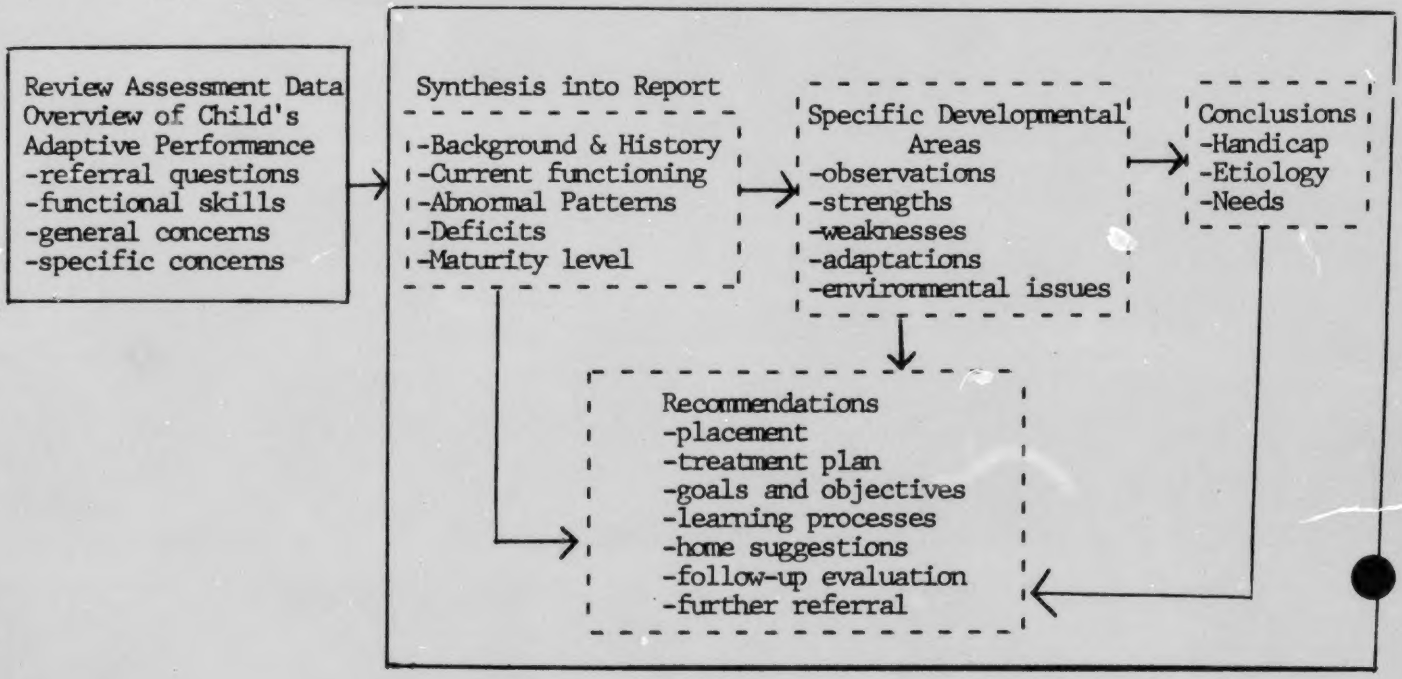
PHASE III. INTERPRETAION - (synthesis)

Whereas in Phase II the emphasis was placed on analysis of the child's capabilities and performance, in Phase III all the information gathered needs to be synthesized. Team members are responsible for their own sections of the evaluation, but it is critical that discussion and exchange of information take place prior to writing the final report. If possible the team should come to consensus concerning the major referral questions. It is helpful to raise some transdisciplinary questions which are relevant to all members of the team and the parents. This may prevent fragmenting the child into "pieces" where each team member talks about his "piece".

For example, a question such as, "In what ways does the child communicate his needs?" will definitely provide an opportunity for the speech and language specialist to share the information obtained about the child's expressive language capabilities. However, it will also serve as a base for comments from the occupational therapist about how the child uses movement to communicate his needs. The psychologist may have input regarding the interpersonal or social communication patterns with the parents. The developmental specialist or teacher may be able to add from observation and testing how the child communicates needs in a group of children and how he communicates his needs when frustrated.

This type of interactive discussion around referral questions leads to more fruitful interchange than merely sharing normative test scores and developmental levels. One purpose of assessment is to provide information for daily programming for the child. A discussion focussed around functional questions will facilitate the emergence of functional data. After an informal discussion of the assessment data, team members need to incorporate their assessment data, observation, and conclusions, and recommendations into a final report.

FIGURE 8. PHASE III. INTERPRETATION (SYNTHESIS)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-weaknesses
-adaptations
-environmental issues
Conclusions
-Handicap
-Etiology
-Needs
Recommendations
-placement
-treatment plan
-goals and objectives
-learning processes
-home suggestions
-follow-up evaluation
-further referral

ORGANIZATION AND SYNTHESIS OF DATA

The organization and synthesis of data should respond to the questions asked in Figure 3 on page 155. Information relevant to both global and specific concerns should contribute to the final recommendations presented in the evaluation report. See Figure 8, Phase III, Interpretation, on page 174. How should the referral (now assessment) questions be answered? The report writing process reflects the data gathering or assessment process (see Figure 6, page 162 in that it proceeds from general to specific. The data is presented first, with the conclusions and recommendations coming at the end of the report. The following suggested format is an adaptation of one presented in Developmental Diagnosis, edited by Hilda Knobloch and Benjamin Pasamanick (1974). The modifications make it more applicable to the educational assessment process.

ORAL PRESENTATION OF ASSESSMENT DATA.

There are specific reasons for the nature of the format of the written assessment report. Various disciplines are trained in the presentation of assessment data. For a team to write a report, it is necessary to address the various areas of evaluation by discipline, thus the report is usually analyzed by developmental area. However, in oral presentation of assessment data, if the information can be discussed in relation to the referral questions, it is easier to generate functional recommendations.

FORMAT FOR THE WRITTEN REPORT ON ASSESSMENT DATA.

I. Identifying information:

name

birthdate

age (or corrected chronological age)

II. Reason for referral.

III. History (use past tense)

  A. Birth weight and duration of gestation.

  B. Pregnancy, labor and delivery and neonatal period. Mention abnormalities specifically associated with high risk.

  C. Significant illnesses.

  D. Convulsions: type of episodes, age of onset, frequency, duration association with fever and treatment.

  E. Developmental history:

  Indicate if normal or in what areas significant deviation occurred, and age at which deviation first was noted. Note specifically if deterioration has occurred.

IV. Informal Observations

  A. Indicate the location and duration of observations.

  B. Discuss interactions observed

    -parent-child

    -child-child

    -child-adult

    -child-objects

    -child-events

V. Tests Administered

  A. List normative tests or sub-tests administered.

  B. List criterion-referenced tests administered.

  C. List other descriptive procedures used (e.g. Piagetian interview).

VI. Qualitative description of test behavior (use present tense)

Mention specific patterns which characterize the behavior of the child. Comments on general description, adjustment to the examination, interest and attention, and quality of exploration of materials are included.

VII. Neuromotor abnormalities

A. Abnormal patterns.

B. Description of any seizures observed during the examination.

C. Mention visual or auditory deficits.

VIII. Interpretation of Test Results

Discuss each behavior in each developmental area separately--adaptive behavior or cognitive, gross motor, fine motor, receptive and expressive language, and personal-social behavior. The assigned maturity level or range is included after each sub-heading. Strengths and weaknesses for each area are discussed. Give examples of behaviors which were observed which indicate patterns of growth or deviation.

IX. Summary of results:

A. Indicate the general maturity levels and the quality of the behavior.

B. Indicate an etiology if data is present to warrant.

C. Summarize major areas of need.

X. Recommendations:

A. Make specific recommendations for

-placement
-treatment
-educational programming
-referral
- home stimulation
-family support

The interpretation of data as presented in the report should be based on objective, empirical data. Emphasis should be placed on the child and families needs rather than on a diagnostic label.

PHASE IV. PROGRAM PLANNING (STAFFING)

The fourth phase is concerned with the formal presentation of assessment data and the joint determination of the child's education placement and program plan. This takes place in a staffing. The Colorado Rules state "the determination that a child is handicapped and the recommendation of placement of that child in a special education program shall be made by a committee of professionally qualified personnel designated by the governing of the administrative unit. The decision of the committee shall be reached by consensus among the prescribed members". The purpose of the staffing is to "insure that children are not misclassified or unnecessarily labeled as being handicapped because of inappropriate selection, administration, or interpretation of evaluation materials".

As outlined in the Colorado Rules the function of the staffing committee is:

- To certify that an assessment of sufficient scope and intensity was completed.
- To provide professional interpretation of results.
- To identify specific educational needs.
- To determine whether the child is elegible for placement in a special education program.
- To identify characteristics of special education services to meet the educational needs of the child.
- To recommend placement in the least restrictive alternative obtainable which most nearly approximates the characteristics of services

identified above.

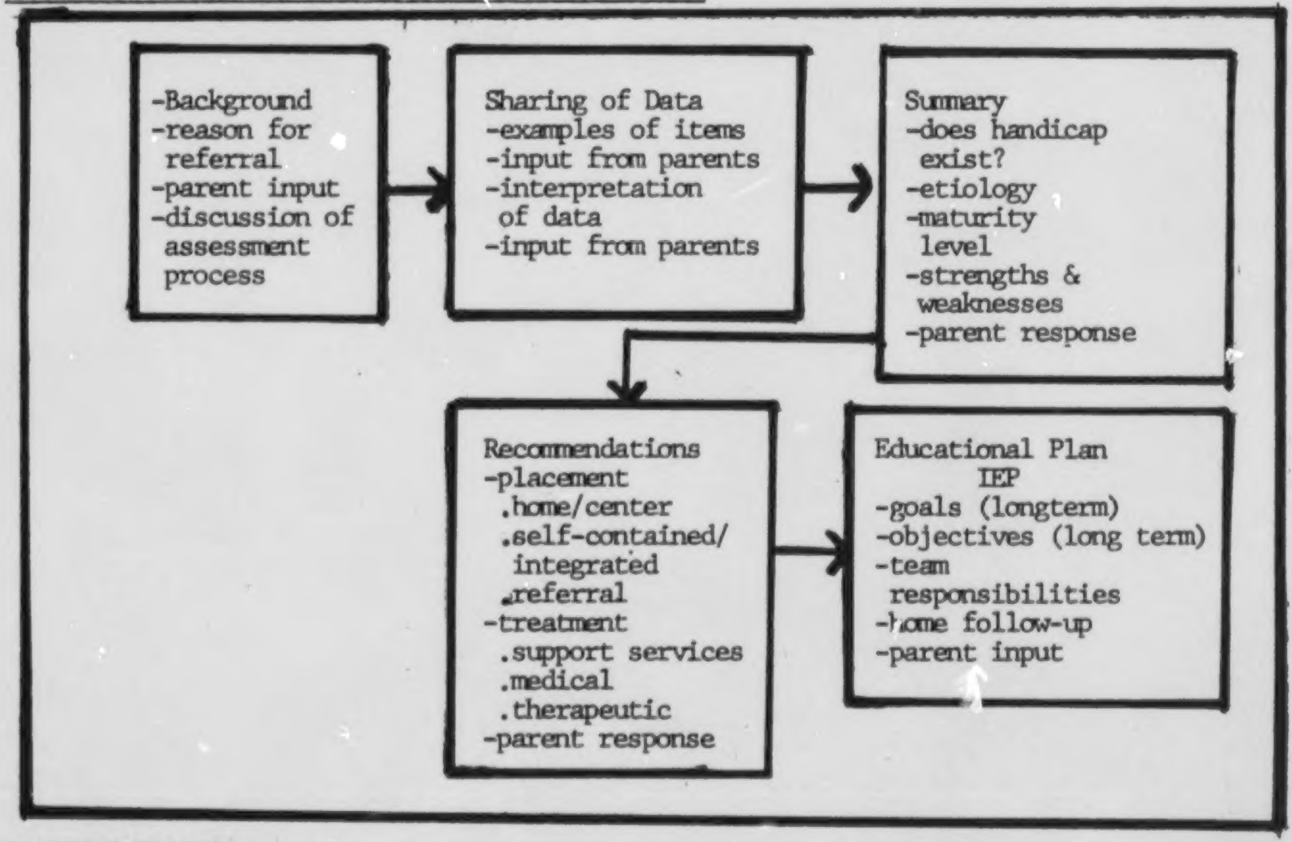
The Rules also indicates that the composition of the staffing committee should include:

- A special education director (or designee)
- A school building administrator (or designee)
- A classroom teacher
- A special educator
- A specialist in the areas of hearing impairment or vision impairment if an educationally handicapping condition in these areas is indicated by assessment.
- A school psychologist
- A school social worker
- Other specialists involved in the assessment team, for example
    - -child find coordinator
    - -a school nurse
    - -an audiologist
    - -a physical therapist
    - -an occupational therapist
    - -a speech and language pathologist
    - -a mobility specialist for the blind
- A representative from other agencies who may be involved in the child's future program (with parental permission)
- Parents of the child

ROLE OF THE PARENTS

The staffing process can seem very threatening to parents who walk into a room to find the above listed persons seated around a table talking about their child. Staffings usually tend to be rather formal with staff using professional terms and jargon. All of this can serve to stifle the parents' desire to offer information, an opinion or even to ask a question. The parent should be viewed as an equal member of the staffing team with valuable information to contribute. After all. who knows their child better? Attempts need to be made to make the parents feel comfortable and to let them know that their input is important. Public law 94-142 also stipulates that parents should be fully advised of their due process rights prior to the staffing.

FIGURE 9. PHASE IV. PROGRAM PLANNING (STAFFING)


-Background
-reason for referral
-parent input
-discussion of assessment process
Sharing of Data
-examples of items
-input from parents
-interpretation of data
-input from parents
Summary
-does handicap exist?
-etiology
-maturity level
-strengths & weaknesses
-parent response
Recommendations
-placement
.home/center
.self-contained/ integrated
.referral
-treatment
.support services
.medical
.therapeutic
-parent response
Educational Plan
IEP
-goals (longterm)
-objectives (long term)
-team responsibilities
-home follow-up
-parent input

STAFFING PROCESS

As the staffing process begins, the case coordinator will present the background information relating to the reason for the child's referral for evaluation. The parents perceptions and/or concerns about their child should be included at this time. This serves an important purpose. If the parents have had concerns for some time, and have an opportunity to express these concerns, they may be more open to the assessment information which will be presented. If, on the other hand, the parents see their child as functioning normally and are upset that the child was referred for evaluation, they may become defensive about the information which is presented. In either case the assessment team needs to present the data very carefully, giving many examples of how the deficits or delays may be seen at home.

The assessment process is described next, explaining what questions the team sought to answer, how the information was obtained, and why the specific instruments or procedures were utilized. The medical and developmental history is traditionally shared first, with additional input from the parents if desired. Each team member then discusses the observational and test data which was gathered. Information is provided on the child's general level of functioning, specific strengths and weaknesses, and learning processes observed. It is often a good idea to give examples of the test items given, while relating them to the behaviors that the parents may observe. For example, the speech and language pathologist might say that the child had difficulty remembering a sequence of three commands. The test item can be stated, "I asked Tommy to pick up the pencil, go put it on the table and then put it under the chair. He was only able to remember the first two requests". The therapist might then ask the parents, "What usually happens at home when you ask Tommy to do several things in a row? For example, pick up your toys, hang up your coat and wash your hands for dinner". If the parents note that Tommy usually leaves out one or more of the requests, they they may begin to understand the relationship between every day behaviors and test items. They may also begin to understand their child's present level of functioning. The parent may add, "I just thought he was being naughty when he didn't mind me". This type of discussion around test data is useful in helping parents to later comprehend the reasons for specific goals and objectives and also makes recommendations for home follow-through more meaningful.

After a thorough discussion of all aspects of the assessment, it is suggested that feedback be obtained from the parents to ascertain their perception of the meaning of all the information which has just been shared. Any misconceptions can thus be clarified. For instance, in discussions of visual perceptual problems, it is not uncommon for parents to think that there is something wrong with the child's eyes. An explanation of what is meant by "visual perceptual" is clearly needed. A summary of the general conclusions of the assessment is then provided answering these major questions:

1) Does a handicap(s) exist?
2) Is there a known etiology?
3) What is the range of the child's levels of functioning?
4) What are the child's strengths and weaknesses?
5) What are the child's needs?

Recommendations regarding the child's placement and treatment plans flow from the answers to these questions. The staffing committee discusses placement alternatives which would best meet the child's and families' needs. Considerations of home versus center-based, self-contained versus integrated or variations of these may be determined. The possibility of providing additional services through another community agency, such as a cerebral palsy center might also need to be discussed. Often it is helpful to list the child's needs and match them with required services. Transportation, medical needs, therapy are examples of possible essential services. The families' needs must also be considered, particularly when infants are being served. A need should not be excluded from identification because the school district has limited staff or services. Means can be sought to provide all needed services through joint agency planning (See Chapter 4 Community Resources).

PARENT NEEDS IN STAFFINGS

It is important to digress briefly before discussing the last aspect of the staffing, the I.E.P. The needs of parents are often unconsciously overlooked at staffings.

Hearing a discussion of diagnosis and placement is often very difficult for parents. It may take time for all of the information to "sink in". The full impact of the diagnostic information and the implications for the child's future may take weeks or months (in some cases even years) to be understood (Turnbull, 1978). One suggestion might be to make a tape recording of the staffing available to parents, so that they can listen again at a later time whenever they desire. Professionals can provide a great service to parents by 1) listening to their concerns; 2) providing time for information to be assimilated; 3) making themselves available for further discussion at another time; 4) not expecting all parents to be emotionally and physically available to carry out all desired follow-through desired by the team. The needs of the family as well as the needs of the child should be important concerns at staffings; 5) providing support services when needed to help parents cope with many difficulties encountered in having a handicapped child.

THE I.E.P.

The final task of the staffing committee is the development of the child's individual program plan. The individual educational program or I.E.P. is a written statement developed by the multidisciplinary staffing committee (including the parents) which outlines the annual goals that are to be met, specific instructional objectives that are to be accomplished, and educational services which will assist the child in reaching the specified goals and objectives.

As directed by P.L. 94-142, the I.E.P. is to include:

1. the present educational level of the child;
2. annual goals;
3. specification of short-term instructional objectives;
4. statements concerning the specific education or related services that are to be provided for the child;
5. the extent to which the child will be participating in the regular education program (unfortunately regular infant and preschool programs may not exist in the school);
6. projected dates for initiation of services and the anticipated duration of services;
7. an evaluation plan outlining the procedures to be used in determining if annual goals and objectives have been met and a state-reflecting how effective the service patterns have been in meeting goals and objectives (Section 212a.348, Federal Register, 1977).

PRESENT PERFORMANCE LEVEL. Utilizing the assessment data, statements regarding the child's present performance in each development area should be given. Physical, medical, and sensory functioning should also be noted.

GOAL STATEMENTS. The areas which are priorities for intervention need to be decided. A general goal statement is written to indicate long-range directions. An example of a goal statement would be "to increase communication skills". In the Office of Special Education Policy Paper on I.E.P.'s, May 1980 an annaul goal is defined as "a statement which describes what a handicapped child can reasonably be expected to accomplish within one calendar year" (P. 21). This technically equivocates to a long-term objective.

LONG TERM OBJECTIVES.

The annual goal statement, as redefined by the Office of Education should be written to state what specific skills will be acquired within a year. Objectives are written in the same manner in which CRT's are developed (see page 171-173) and, in fact, many persons use CRT's as a basis for the long-term objectives. The components of an instructional objective include:

1. The learner for whom the objective is intended.
2. A statement of the precise, observable behavior that the learner is expected to display.
3. The conditions under which the learner is expected to display the behavior.
4. The criteria for successful performance of the behavior. (Van Etten, Arkell, and Van Etten, 1980, p. 139).

An example of a long-term objective would be "Tommy will identify twenty common household items when requested with 80% accuracy".

SHORT-TERM OBJECTIVES.

Short-term objectives are written in the same manner, only they indicate steps or skills which will be accomplished on the way to achieving the long-term objective. In relation to the above stated long-term objective, an example of a short-term objective might be: Given the verbal clue "show me the cup", Tommy will point to the cup four out of five consecutive trials.

Short-term objectives are usually derived from long-term objectives, and indicate where instruction is to begin. Van Etten et. al. (1980) suggest the following guidelines for selecting objectives:

1. Incorporate major parental concerns with regard to skills for the child.

2. Consider physical or medical concerns in selecting of skills needed.
3. Select skills that will contribute to the child's functional independence.
4. Select skills from various developmental areas which are functionally related.
5. Consider how meaningful it is to a child at the time it is to be taught.
6. If a child is in the program for a brief period of time select critical skills to be achieved.
7. Consider objectives which can be accomplished in small groups.
8. Objectives should fit into a developmental sequence.
9. Select skills which are appropriate for the child's rate of learning.
10. Select skills that can be used in the home so that maintenance and generalization of skills is facilitated.
11. Classroom objectives should complement those of other team members.

EDUCATIONAL AND RELATED SERVICES

The special education services to be received as well as services beyond the classroom which will be provided are designated on the IEP. The rules and regulations (Federal Register, 1977) specify the following as "related services":

-transportation
-speech pathology and audiology
-psychological services
-physical and occupational therapy
-recreation
-counseling services
-medical services for diagnostic and evaluation purposes
-school health services
-social work services
-parent counseling and training (pp 42479-42480).

Art, music, dance, and physical education are also considered related services when appropriate.

PARTICIPATION IN REGULAR EDUCATION

Many public schools do not at this time provide education to normal infants and preschoolers, which limits the type of environments available for "least restrictive" placement. However, whenever possible joint efforts with local preschools should be planned to provide opportunities for mainstreaming. Any formal arrangement for mainstreaming should be noted on the IEP.

PROJECTED DATES FOR INITIATION OF SERVICE

Most personnel interpret the initiation and duration to refer to the amount of time projected for each objective. Thus team notes the anticipated length of time needed to accomplish the objectives.

APPROPRIATE EVALUATION PROCEDURES

Whatever procedure will be used to evaluate performance needs to be stated. Continuous measurement, checklists and probes are examples of methods of evaluating progress.

The development of the IEP is the culmination of the assessment process. Although all team members and parents have input, the developmental specialist or early childhood special educator and other team members who will work directly with the child have the major responsibility for the writing of the I.E.P.

GUIDELINES FOR STAFFINGS

1. Parents must be notified of the staffing and given every opportunity to attend.
2. Parents must be informed of their right to be represented by counsel and of their right to appeal.

3. The staffing process should be discussed with the parents beforehand so they will not be overwhelmed by the process.

4. The social worker, case manager, or teacher, (a person with whom parents have established good rapport) should sit by the parents and function as a support and to encourage their involvement.

5. Remarks to be presented should be prepared using lay language. Terms which parents and other staff might not understand should be defined.

6. Practical examples of the child's behaviors, such as the parents might observe at home should be given to help illustrate deficits found in testing.

7. Major referral questions should be addressed in the summary of test data.

8. Recommendations should eminate from data gathered.

9. Consider family needs as well as child needs.

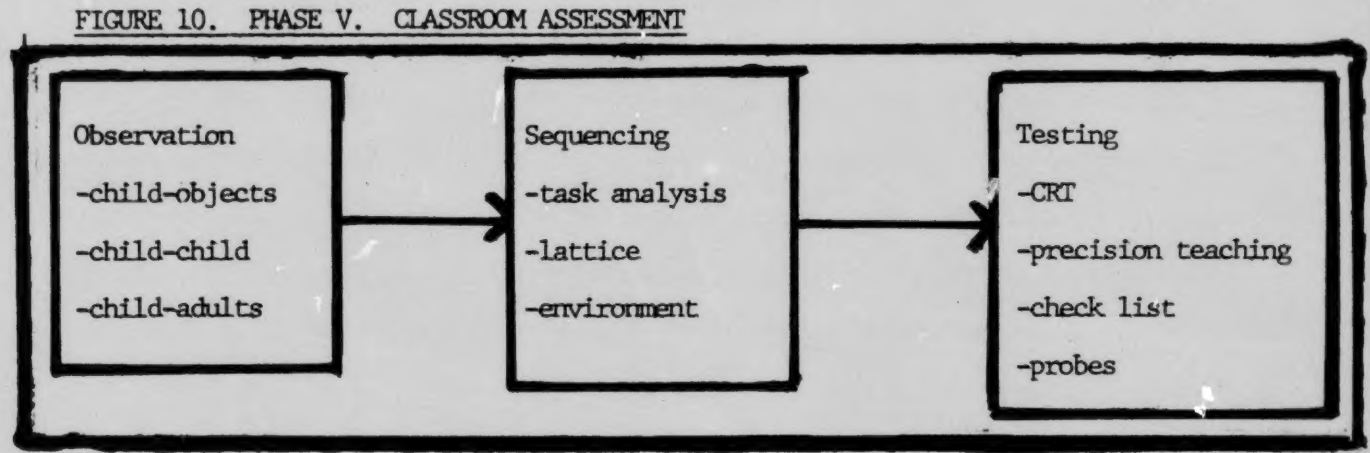
10. Services needed by the child and family should not be eliminated because of shortage of staff or funds. Pursue interagency agreements.

11. I.E.P.'s should be developed consistent with federal and state guide lines.

STAGE V. CLASSROOM ASSESSMENT

Classroom assessment is the continuous evaluation of the child's progress. It usually occurs after the child has been placed in the program and is done by the teacher and other team members. Classroom assessment begins with the I.E.P. and proceeds throughout the year. Depending on the level of severity of the children's handicaps, the program philosophy, and the curricula utilized this assessment will take different forms. The process is similar, however, regardless of these variables. (See Figure 10, page 189)

FIGURE 10. PHASE V. CLASSROOM ASSESSMENT


Observation
-child-objects
-child-child
-child-adults
Sequencing
-task analysis
-lattice
-environment
Testing
-CRT
-precision teaching
-check list
-probes

Every day within the classroom (or the home) the staff observe the child and notation is made of the child's interactions with objects, events and people within the environment. Specific attention is paid to

- -the times when the child is most attentive and receptive.
- -the length of time of maximum concentration.
- -the materials, toys, people, and events which are most stimulating to the child.
- -the methods (demonstration, modeling, imitating, physical or verbal prompting, questioning, etc.) that are most effective in promoting learning.
- -the mode of response preferred by the child
- -the sensory modalities stressed by the child
- -the physical setting which is most conducive to exploration and involvement.
- -the types of peer involvement which encourage social growth
- -the adult-child interactions which are most effective in promoting positive growth (types of reinforcement, directive, and/or playful interactions)

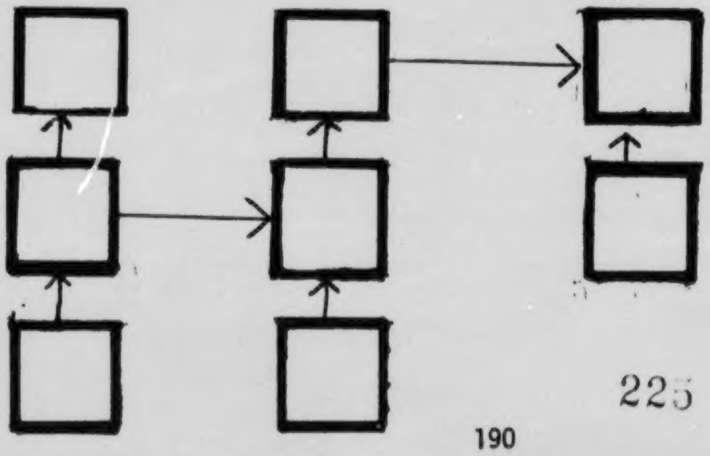
As the staff assess the child within the environment, patterns begin to emerge which are useful for program planning. This type of observation over time can usually not be done in the diagnostic assessment, but is important as it provides the key to successful teaching. The child's patterns may also change over time so these observations need to be on-going.

The observational data plays an important role in the second aspect of classroom assessment, the sequencing of skills to be assessed. The most common method of sequencing involves task analysis. Howell (1979) defines task analysis as "the process of isolating, sequencing and describing all of the essential components of a task" (p. 81). Van Etten, et.al. (1980) describe the following five steps of task analysis:

1. Identify the terminal behavior (task) to be learned, as stated in the instructional objective.
2. Derive the components of the task and then sequence them.
3. Determine any prerequisite skills needed for the subtasks.
4. Eliminate nonessential and/or redundant component and prerequisite skills.
5. Consider the need for task slicing of component skills.

Task analysis allows the staff to assess exactly where a child is in relation to learning a particular skill. It is particularly useful when working with severely and profoundly handicapped children.

Another method of assessing where a child is in relation to a learning sequence is the use of a developmental lattice page 213). The tasks in each column are listed upwards with the lowest prerequisite at the bottom. Interrelationships can also be depicted among skills as they relate horizontally.



The advantage of a lattice is that the interrelated nature of various skills and areas of development can be clearly seen. Analysis of where a child is on a lattice may reveal that one reason the child is not learning a skill is that she doesn't possess a related, concurrently developing skill. For example, a blind child may not be crawling much even though the physical ability is present. One reason may be that the child is not actively pursuing objects for play, an item which is a cognitive skill emphasizing the use of vision. The teacher may then alter the child's program to encourage locomotion toward a desired auditorily stimulating toy.

In programs for mildly handicapped children, sequencing of specific events within the environment may allow the teacher to observe a child's developmental level within a series of structured events. The teacher, for example, requests that the child plan, carry out, and describe an activity. Depending on how the child does this, the teacher obtains information on the child's cognitive abilities, (knowledge of time, sequencing, memory) as well as the child's language and motor abilities. From such observational assessment, the child's program can be modified to provide activities which will work on multiple skills at appropriate levels.

Finally, the staff do ongoing testing in a variety of ways. Precision teaching models which utilize charting of skills, CRT's, checklists, probes, anecdotal records are all ways of assessing progress. Again the methods chosen will depend on the population and the philosophy.

SUMMARY

The assessment model presented in this chapter emphasizes the dual nature of child evaluation.

1) Assessment should present inter-individual information on the nature of the child's performance in relation to other children of the same age. This

data is useful for placement and service decisions.

2) Assessment should present intra-individual information on the specific skills which the child has and on those which are ready to be learned. This data is necessary for decisions concerning the child's classroom program and to provide a means for measuring the child's progress within that program.

A five stage assessment design is recommended which includes:

Phase I	Assessment Planning
Phase II	Assessment (analysis)
Phase III	Interpretation (synthesis)
Phase IV	Program Planning (staffing)
Phase V	Classroom Assessment

The inclusion of Phase V, classroom assessment, demonstrates the ongoing nature of evaluation assessment is a dynamic process which should be an integral part of the child's program--from before he enters the special education service delivery system until he "graduates" from the system.

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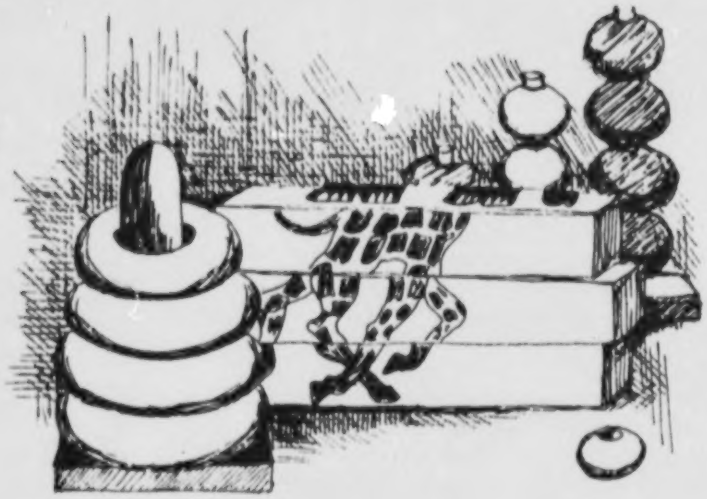

SIX

SELECTING AND UTILIZING CURRICULA

Curriculum generally refers to "systematic procedures for organizing educational activities; the procedures include both content (what to teach) and method (how to teach)" (Lillie, 1975, p.2).

Content areas in elementary school, typically revolve around the "three R's", with the academic areas relating to reading, writing and arithmetic. However, programs at the preschool level have had various approaches to curriculum, as outlined in Chapter 3, "Conceptualizing and Developing a Program." Programs for handicapped preschool children have evolved from and expanded upon these different themes, styles, and techniques.

What are the "essentials" to be taught to handicapped children? There exists a number of assessment instruments and curricula in early childhood special education. These curricula vary in a number of significant ways. The team or persons responsible for selecting or designing a curriculum for their program need to be cognizant of program areas and sequences within components.

MAJOR PROGRAM AREAS

Major program areas are the general areas in which children will be instructed. These components may stress development areas, specific skills areas, or enrichment areas: 1) Many early childhood curricula are divided into general developmental areas such as gross and fine motor, expressive and receptive language, cognitive or adaptive reasoning and social/emotional. 2) Other major program areas may be designated by specific skill areas, such as self help skills, pre-reading and pre-math skills, and communication skills. Sensory skill areas such as visual or auditory areas may also be represented. 3) Still other curricula will designate major program components which integrate developmental or skill components into enrichment activities such as art, music and dance.

There are generally five categories recognized as appropriate areas of instruction for young handicapped children (Van Etten, Arkell, and Van Etten, 1980).

1. Motor development
2. Self-help skills (activities for daily living)
3. Sensorimotor, cognitive development (pre-academic)
4. Communication (language)
5. Social/interpersonal development (socialization, personal-social, social/emotional) (p.209).

Regardless of the title of the component in the curriculum, whether it is designated as a developmental area, skill area, or enrichment area, it is important that each of the above dominions be represented in some way in program planning. Particularly for handicapped children, difficulties with one area may have a profound influence on other areas of development. Emphasis on one curriculum component may result in an unbalanced program, one that does not totally meet each child's individual needs. The necessity for a team or interdisciplinary approach is evident to maximize information exchange and ensure optimal programming for each child in all developmental areas.

SEQUENCE WITHIN COMPONENTS

Cohen and Gross (1979) indentify variations of curriculum sequences. A curriculum may utilize all four types of sequences or may emphasize one or two. The important consideration for the team is to utilize a curriculum which pinpoints the instructional needs of their population and is consistent with their program philosophy.

The variations of sequences of abilities include:

1. -arrangement according to targets in a specific area. For example in the area of self help, sub-areas might be feeding, toileting, dressing, with skills listed under each respective sub-area in a task analysis. Such sequences are usually utilized in behaviorally oriented programs.

2. -arrangement according to developmental milestones. In some cases a curriculum will list all the milestones a child generally accomplishes in a given year. For example, a curriculum might list the following skills under the cognitive area for 3 to 3½ years:

copies a circle
copies a four block train with chimney
imitates straight cross
puts together a two-piece puzzle

It is important to note that the items are not listed as prerequisites to the next item in the sequence. This sequence listing is probably most appropriate for mildly involved children who acquire skills without intensive training.

In other instances, the curriculum may list objectives in sequences leading to major milestones. For example in the development of object permanence, the curriculum may list:

--finds object hidden under one screen
--finds object hidden under one of two screens
--finds object hidden under one of two screens alternately
--finds object after successive visible displacements

With the former listing of milestones by age, if the child was unable to perform one of the skills, the teacher might not know what prerequisite skills were necessary. The latter listing of developmental sequences allows the teacher to determine a teaching sequence based on developmental prerequisites. It is particularly appropriate for severely involved children as the sequences can be finely denoted.

3) -arrangement according to constructs. Some curricula designate constructs to be attained that become the basis for activities. Piagetian constructs such as ordination, cardination, conservation, provide areas which are then broken down into developmental tasks. Part of a sequence under the construct of seriation might include:

understanding of big and little
understanding of tall and short
understanding of largest
understanding of tallest
understanding of middle

Curricula designed to develop specific constructs are generally experientially rather than behaviorally oriented.

4) -arrangement according to stimulus characters. Developmental progressions in areas such as vision and audition may relate to characteristics of the stimulus.

--prefers circular to linear arrangements
--shows preference for checkboard over regular lattice arrangement of circles, squares, diamonds
--fixates somewhat longer on male and female patterns than on other patterns
--discriminates differing orientations of the face.

Such stimulus character arrangements would be useful in designing programs for visually, auditorally impaired or learning disabled children.

Since most early childhood programs are non-categorical in nature, the ideal curriculum would probably incorporate elements of each of the above mentioned sequence formats. However, as the ideal curriculum to meet all handicapped children's needs is yet to be developed, the intervention team is advised to select a variety of curricula as resources. All handicapped children are different and their programs and strategies should reflect individual learning styles.

A specific curriculum or set of curricula will not be recommended in this text. However, an effort will be made to delineate recommended program areas and sub-areas of importance in early childhood special education programs. A rationale for inclusion of each area is suggested to emphasize the interrelated nature of each component with the others. It is implied that a team of professionals would work closely together to further expand and delineate needed sub-components.

GROSS AND FINE MOTOR DEVELOPMENT--RATIONALE

The development of volitional movement can be said to be the foundation of development in all other areas. It is, perhaps, the most overlooked curricular area in many programs with the exception of programs for the physically handicapped.

The development of gross and fine motor skills is usually sequential and fairly predictable, with skills emerging as the nervous system matures. With the handicapped child, however, there may be delays and/or deviations in motor development which will interfere with the normal sequence of skill acquisition. These delays or deviations will undoubtedly have an effect on other areas of development.

Let us examine how problems in gross and fine motor development will effect perceptual-motor, self-help skills, cognition, language and social/emotional development. In order to function well in the environment, a child needs balance, stability, coordination of both sides of the body, rotational abilities, a fairly broad range of motion, adequate muscle tone and muscle strength, and volitional control of movements.

Without these abilities, the child cannot have maximum interaction with his environment. For example, inadequate head and trunk control will limit visually directed reaching and consequently reduce fine motor manipulation of objects. Difficulty with balance in sitting may limit bilateral manipulation of objects. The child who must concentrate his efforts on resisting the pull of gravity will need to use his extremities as props rather than exploratory tools. The child with inadequate motor control may not be able to explore his own body and move around to explore the environment as a normal child does. The handicapped child may consequently have reduced or limited visual, tactile, auditory, gustatory and olfactory experiences. This reduction of sensorimotor experiences may result in limited body awareness, delayed or inaccurate development of form and space perception (Fantz and Yeh, 1979). If a child has limited motoric exploration it may thus affect cognitive development as well. For example, major cognitive skills such as object permanence, using tools as a means to attain desired ends, classification of objects according to shape, sequencing of objects in order of size---all are achieved after much manipulation and experimentation with the objects in the child's environment. The child learns through acting upon the environment. Motor problems result in a limited ability to move and to manipulate objects, to cause events to occur and to interact with people. The result is reduced learning opportunities.

The development of language skills may also be affected by motor problems. Inadequate head and trunk control may interfere with breathing patterns and thus affect phonation required for speech. Inability to control oral musculature will affect speech production. Limited exploration of the environment may result in formation of fewer concepts and thus a reduced ability to label objects and environmental events. Both receptive comprehension and expressive language may be delayed, especially as related to spatial concepts and actions.

Inadequate head and trunk control, stability, and equilibrium may hinder development of feeding, dressing, toileting and other self-help skills. In addition, difficulties with muscle tone, muscle strength, and motor planning may effect academic skills such as writing, cutting, drawing, etc. A great many academic skills for young children require gross and fine motor coordination.

Emotional development and the growth of social skills are greatly influenced by the child's physical abilities. When attachment between mother and infant is first taking place, the child communicates primarily through physical cueing. Looking, touching, cuddling, smiling, crying are all behaviors with motor components to which the mother reacts (Brazelton, Koslowski, and Main, 1974; Klaus and Kennel, 1976). The physically handicapped child may not have adequate cueing mechanisms to encourage reciprocal positive interaction. Predominant extensor patterns may inhibit cuddling. Reduced smiling behaviors (Cicchetti and Sroufe, 1975; Emde, Gaensbauer and Harmon, 1976) may diminish playful interaction. Increased and intense crying may result in less handling and inattention or possibly more holding but less mutual needs gratification. The child with motor problems is at greater risk for attachment failure (Foley, 1980). Later in the child's development this cycle of insufficient needs fulfillment may expand to include teachers and peers.

The child who doesn't perform competently in skill areas, may recognize his limitations. The awareness of physical inadequacy may affect the development of self-concept and social interaction. Play opportunities and social interaction may be limited or reduced with the possible consequences of inadequate or delayed social skills. The child may experience a delay in the development of independence as a result of continued assistance from caregivers.

Many times cognitive delays coincide with motoric delays but often the motorically involved child is unable to demonstrate the cognitive skills of which he is capable. The result is frustration for the child and often misdiagnosis on the part of staff who perceive the child as cognitively delayed as well.

As can be seen by these few examples, the motor area is a critical component of the curriculum. Although the type of curriculum chosen for the gross and fine motor areas will depend largely on the needs of the identified population of children, it may be helpful to examine components of a motor curriculum which are important. Staff can then examine various curricula to determine whether or not assessment, sequences and program strategies for these components are adequately addressed. No effort will be made to list all skills which should be included, but staff are encouraged to look for curricula in which related skill areas are developmentally sequenced rather than grouped by all motor skills which are normally attained at a given age.

The importance of reflexes and automatic reactions should be recognized. Reflexes facilitate the development of motor and cognitive skills. Integration of certain reflexes is critical to the appropriate development of gross and fine motor skills. However, reflexes should not be targets to be "trained". Instead volitional movements that are incompatible with the reflex, are appropriate for program objectives. It is not possible to train a "grasp" reflex, however, "holding" as a skill can be a curriculum objective. The importance of having a physical or occupational therapist on, or consulting with, the team to work on the development of program plans in the motor area can readily be seen

REFLEXES AND REACTIONS

Prior to the development of program objectives the therapist will want to evaluate the child's reflexes and reactions. Bobath (1974) looks for delayed or abnormal development with;

1. An insufficiently developed postural reflex mechanism, showing itself, for instance, in poor head control, lack of rotation within the body axis, and lack of balance and other adaptive reactions.

2. A lack of inhibition showing itself in unduly prolonged retention of the primitive patterns of earliest childhood (p.2).

Connor, Williamson, and Siepp (1978) recommend that analysis of skills the child has acquired should be done according to the following:

1. What components of movement are necessary in order for the child to have mastered a particular skill?

   -integration of primitive reflexes
   -righting reactions
   -equilibrium reactions
   -protective reactions
   -normal sensorimotor development

2. For what future skills can a particular skill be considered an important component?

3. What areas of developing cognitive, language, and social ability are likely to be facilitated by a motor act? (p.103).

After evaluating the child's motor development in relations to the above questions, the child's motor program can be planned. The curriculum should include activities to facilitate the integration of primitive reflexes and the development of righting, equilibrium and protective reactions as well as activities for development of sequences of motor skills. The following are

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sub-areas of gross motor development. Each area listed should be broken down into developmental sequences in the curriculum.

- Head-righting - prone
  - supine
  - upright
- Joint stability - upper arms
  - trunk
  - hips
  - legs
- Rotation - prone to supine
  - prone to sitting
  - rotation in standing
- Progression on hands and knees
- Progression to sitting
- Progression to crawling
- Progression to standing
- Progression to walking
- Progression to jumping
- Progression to skipping

The fine motor component of the curriculum should illustrate and define progressions in the differentiation and progressive development of prehension and fine muscle control. Included should be sequences related to:

- Progressions in visually tracking objects or visual pursuit
- Progressions in focusing
- Progressions in head and trunk control
- Progressions in reaching
- Progressions in voluntary grasp
- Progressions in voluntary release
- Progressions in throwing of objects
- Progressions in catching
- Progressions in thumb and finger opposition
- Progressions in drawing
- Progressions in writing
- Progressions in coordination of use of two hands simultaneously

Each of the above mentioned progressions may be sequenced in varying degrees of detail. For severely involved preschool children it may be necessary to develop subtle, more finely differentiated steps in the developmental progression. It may also be necessary to task analyze individual steps into chains of behaviors leading to one step of the sequence.

I. Progression

   A. Developmental step 1
   B. Developmental step 2
   C. Developmental step 3

      1. Task analysis of step 3

         a. Sub-step 5
         b. Sub-step 4
         c. Sub-step 3
         d. Sub-step 2
         e. Sub-step 1

   D. Developmental step 4

In the above example, the child acquired skills sequentially up to developmental step 3. At this point the skill was task analyzed and taught through a "backward chain". After accomplishment of step 3, the next step in the developmental sequence became part of the child's program.

SENSORY INTEGRATION-RATIONALE

Sensory development in the child has become an area of intense study in the past ten to fifteen years. Research on visual perception (Campos, Langer, and Krowitz, 1970; Fantz, 1979; Haith, 1980; Kessen, 1976) auditory perception (Brackbill, 1970; Bridger, 1961; McGurk et. al., 1977); tactile perception (Brackbill, 1970; Rice, 1975); vestibular/proprioception (Korner, Thoman, 1972; Pick and Pick, 1970); gustation (Nowlis and Keesen, 1976); olfaction (Engen and Lipsitt, 1965) has shown the importance of these sensory systems to the developing child. The integration of information coming into the central nervous system from each of these systems provides the foundation of the child's perceptions of the world and consequently the basis for his/her conceptual understanding. If the child has inadequate or inaccurate sensory input to the CNS or problems with processing the information once it has reached the CNS, the child's other developmental areas may be adversely affected.

For example, inadequate perception of gravity and the body in space may interfere with the child's efforts to coordinate his movements. The develop- of motor skills will be affected by the child's awareness of his body's movements in space. Without accurate information from tactile and kinesthetic and/or proprioceptive systems the child will not have optimal volitional control of body movements. Refinement of fine motor skills may be also impeded, as inadequate perception of spatial relationships may interfere with basic skills such as reaching for objects, accurately placing objects, or manipulating objects in goal-oriented actions.

Cognitive growth may also be delayed or hampered by the inadequacy of sensory systems. If the information processed by the brain is inaccurate or inconsistent, the child may develop a distorted understanding of his environment. A child who has difficulty making sensory discriminations may be hesitant to interact with the environment. For example, a child who is tactilely defensive may withdraw from contact with persons or objects. The child consequently does not take in as much information about the environment, does not optimally interact and experiment in order to ascertain the relationships between objects and events and will therefore be delayed in problem-solving abilities.

Behavioral problems may also be seen in children with inadequate sensory systems. The child may be overly sensitive to stimuli, or easily frustrated by the inability to process and make sense out of environmental perceptions. A child with difficulty discriminating, for instance, visual or auditory patterns may react by withdrawal from such stimulation or may act out from a sense of being "overwhelmed". Continued failure in interpersonal and object interaction may result in an impoverished self-concept.

The area of sensorimotor, perceptual motor, or sensory integration as it is variously titled is becoming an increasingly important curriculum area. Its pivotal nature is apparent as it is closely related to gross and fine motor and cognitive development and certain progressions of skills, such as tracking and object manipulation which may be found in more than one area.

Identification of areas of instruction in sensory development involve providing activities to utilize the strong sensory systems and enhance the impaired systems. Van Etten, Arkell and Van Etten (1980) list primary curriculum tasks in three primary sensory areas:

Tactile

-accepts touch
-allows directed body movement
-explores with mouth
-localization of touch
-responds to and begins to discriminate between
 various tactile stimuli
-uses tactile sense to explore environment
-thermal awareness

Visual

-sensation
-visual fixation
-visual tracking
-convergence
-eye contact
-reaching and grasping
-eye-hear coordination
-eye-hand and eye-foot coordination activities

Auditory

-cries or startles in response to sound
-responds by quieting, stopping movement
-localization
-discrimination (p.210)

These tasks can be broken down and extended as necessary to include more discriminating and/or higher level targets. Again, the importance of an occupational or physical therapist is emphasized, as this team member can have valuable input both in terms of assessment of sensory deficits and planning remedial strategies.

COGNITIVE DEVELOPMENT-RATIONALE

The cognitive or adaptive reasoning curriculum area is heavily emphasized in most programs. The importance of cognitive abilities to academic or school success is readily apparent, and thus, justification for its inclusion hardly seems necessary. Yet it is significant to note the impact of cognitive delays on the other areas of development.

Problems in cognitive development may affect the rate at which motor skills are acquired. The child may take longer to understand the various properties of objects and the functional use of these objects, so complementary motor "schemata" or patterns may also be delayed. The child may have a reduced comprehension of environmental events and a resultant diminishment of the desire for object or interpersonal interaction which allows the practicing of motor skills to take place. In addition, the lowered capacity for applying motor skills in new situations may have the effect of hindering the generalization of motor actions. For example, the child who learns to poke his fingers in the holes in the peg board, may not generalize that skill when he finds other holes in other toys. The motor skill of finger differenciation does not then get practiced as often. Therefore "classification" of motor schemata into complex motor planning actions may take longer to accomplish.

The child with delayed cognitive development may have a heavy reliance on a trial and error or perseverative approach to learning and thus have a reduced number of problem-solving strategies involving movement and manipulation. The child may, for instance, persist in one approach to putting a puzzle together.

By not experimenting with moving the puzzle pieces into different positions he is not exercising precise finger movement, eye-hand coordination, or perceptual discrimination.

The overall delay in learning skills will also affect the rate, quality, and quantity of language acquisition. Diminished conceptual understanding will affect both receptive and expressive abilities. Higher level symbol representations will be understood primarily through concrete experiences. Abstract concepts will take longer to comprehend or may never be functional aspects of the child's language system. Learning irregular language forms of plurals, past tense, and other syntactic structures may be difficult. Generalization of grammatic rules may also take much longer in the cognitively delayed child.

In relation to social skills, the child may not pick up on subtle social cues which are necessary for appropriate behavioral adjustment. The understanding of "cause and effect" relationships entailed in social situations are cognitively higher level skills than understanding cause and effect relationships in concrete situations involving objects. The cognitively delayed child may therefore take longer to understand why an action or event makes someone "angry", "sad", "happy", etc.

The child may also have at his disposal fewer problem-solving skills. She/He may not be able to see alternative means for accomplishing a goal. This can lead to frustration both in dealing with concrete problems involving object use for obtaining a desired end and also in interpersonal interactions when dealing with social problems. The implications for the development of the self-concept are evident.

Self-directed play may remain at the lower level of "isolated" or "parallel" play (Parten, 1932) longer. The child's level of representational thinking may be inadequate to process symbolic information necessary for cooperative and dramatic play. For example, whereas a normal preschool child may use blocks to represent buildings, roads, towers, and bridges, the cognitively delayed child may still be constructing "patterns" with blocks. He cannot visualize the block as anything other than a piece of wood. Socialization skills which develop through cooperative dramatic play will consequently be affected.

The discrimination and generalization of social skills may be problematic. The child may, for example, learn that "hugging and kissing" is very reinforcing. She/He may indiscriminately and inappropriately hug and kiss everyone. On the other hand, the child may learn not to perform an inappropriate action, such as screaming, at school, but that learning may not generalize to the home. Such "situation specific" learning can cause increased problems particularly in the area of social skills.

Given the significance of the cognitive area and its impact on other areas of development, the skills outline in this area of the curriculum need to be quite comprehensive. The following are suggested skill areas in cognitive development. These need to be further defined according to the needs of the population being served.

COGNITIVE SKILL AREAS

- Attending to stimuli
- Tracking stimuli
- Hand regard
- Visually directed grasping and reaching
    - -bilateral
    - -unilateral
- Object permanence progression
- Means-ends progression
- Differenciated object use progression
- Social object usage progression
- Representational object usage (beginning classification) progression
- Objects relation in space progression
    - -utilization of space relations
        - -places objects in, out, on top of

- -builds vertical structures
- -builds horizontal structures
- -builds vertical-horizontal structures

Operational causality progression
Gestural imitation progression
Vocal imitation progression
Classification by characteristic of objects pregression

- -color
- -shape circle, square, triangle, rectangle)
- -understands same and different
- -size
- -function
- -multiple characteristics

Drawing progression

- -marks
- -scribbles
- -controlled strokes-vertical, horizontal, angle, circle, cross
- -reproduction of forms
- -draws people
- -copies letters
- -writes letters spontaneously
- -writes name
- -writes numbers

Class inclusion progression

- -within one set
- -within a hierarchy

Concept of ordering progression

- -big, little, largest
- -tall, short, tallest

Concept of seriation progression

- -size
- -color
- -number, cardinal correspondence
- -correspondence of sets
- -ordinal correspondence

Rote counting
One-to-one correspondence progression/rational counting
Numeral identification
Comparison of sets progression

- -all, empty
- -each
- -more/less
- -same

Conservation progression

- -length
- -number
- -continuous quantity
- -discontinuous quantity
- -volume

Addition progression (in relation to above)
Subtraction progression (in relation to above)
Time concepts

- -now, today
- -past tense of verbs
- -past, present and future words
- -duration of time

    - part of day - morning, afternoon, night
    - before/after
    - early/late
    - time on the clock

Money concepts

    - identify coins
    - identify uses of money
    - understand value of coins and bills
    - reading numerical amounts

Calendar concepts
Measurement
Fractions

LANGUAGE DEVELOPMENT - RATIONALE

Examination of the impact of the area of language development on the total development of the child reveals the necessity of including both receptive and expressive domains into any curriculum for handicapped children.

Inadequate language comprehension may indirectly affect gross and fine motor performance. If the child does not accurately hear or interpret verbal directions, the child will not be able to respond with the appropriate response - which usually entails a motor component. This may be misinterpreted by the teacher as an inability to perform the skill requested.

A deaf, hard-of-hearing or severely language impaired child may need to substitute or supplement oral language with sign language. Thus, the development of parallel language systems, oral and gestural, may be indicated.

The relationship of language and cognition is a controversial issue (Bruner, 1972; Bruner, Olver, and Greenfield, 1966; Piaget, 1962, 1963, 1973) but regardless of which serves as the foundation for the other, the interdependence of the two areas is undeniable. Language is a primary means by which one demonstrates understanding of concepts, processes and events, particularly comprehension of abstract concepts and relationships. A child's inability to demonstrate cognitive understanding through verbal expression may lead to lowered appraisal of cognitive skills and consequent lowered expectations on the part of the teacher. Concurrently, reduced motivation and/or frustration on the part of the child may be demonstrated. Conversely, some children have learned to parrot extensive phrases without true comprehension of the content of their speech. These children may be viewed as having higher level cognitive skills than are actually present. The teacher's level of expectations for these children may be too high, with resultant frustration for both.

In the area of social skills, the child who cannot effectively make his/her needs known and cannot verbally express feelings may resort to alternative means of self-expression. For example, acting-out behaviors, or actions which are abusive to self or others may be manifested. On the other hand, withdrawal from interpersonal interaction may also occur. Children with lower language skills may not be sought out by peers for social interaction (Guralnick, 1978). In either case, socialization skills are being adversely effected. Other children may also become frustrated and reduce interactions with the child who does not comprehend or cannot communicate well.

There appear to be some cognitive prerequisites that underlie language development. Bates (1976) has identified some of these precursors:

1) awareness of object permanence
2) awareness of spatial relations
3) awareness of the understanding of means-end
4) development of deferred imitation
5) development of rational and pretend play
6) development of communicative intentions

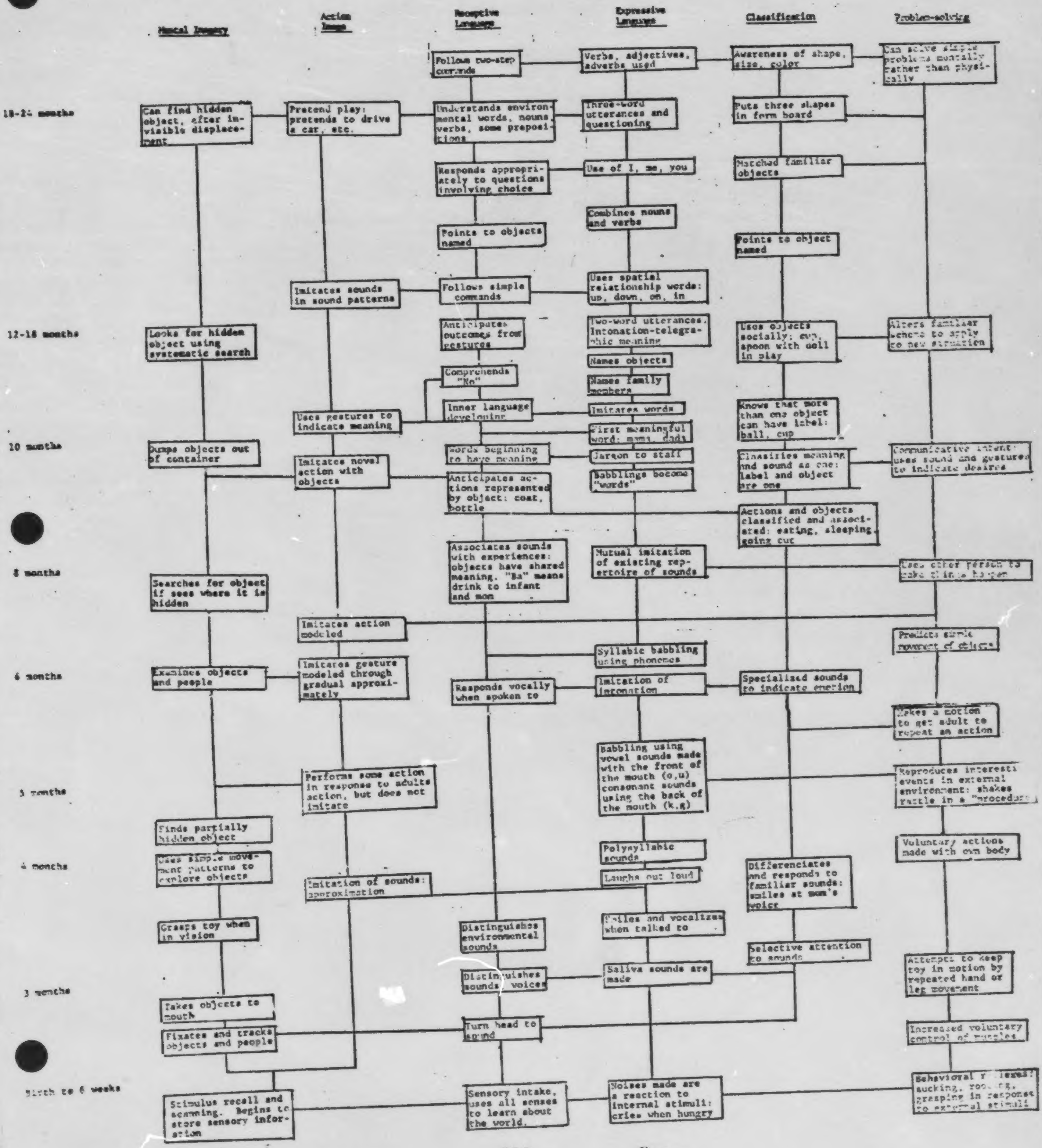
These target areas should be included in or referenced in the language area of the curriculum.

DEVELOPMENTAL SEQUENCES IN LANGUAGE ACQUISITION

The relationship of skills to each other within a developmental sequence is important. The following lattice of cognitive and language skills from birth to 24 months demonstrates how areas of the curriculum may be interrelated. (See page 213) The number of skills and degree of specificity may vary depending on the population

Table I.

LANGUAGE/COGNITIVE LATTICE FROM BIRTH TO 24 MONTHS


Mental Imagery
Action Image
Receptive Language
Expressive Language
Classification
Problem-solving
Follow two-step commands
Verbs, adjectives, adverbs used
Awareness of shape, size, color
Can solve simple problems mentally rather than physically
18-24 months
Can find hidden object, after invisible displacement
Pretend play: pretends to drive a car, etc.
Understands environmental words, nouns, verbs, some prepositions
Three-word utterances and questioning
Puts three shapes in form board
Responds appropriately to questions involving choice
Use of I, me, you
Matched familiar objects
Combines nouns and verbs
Points to objects named
Points to object named
Imitates sounds in sound patterns
Follows simple commands
Uses spatial relationship words: up, down, on, in
Anticipates outcomes from gestures
Two-word utterances. Intonation-telegraphic meaning
Uses objects socially: cup, spoon with doll in play
Alters familiar schema to apply to new situation
12-18 months
Looks for hidden object using systematic search
Comprehends "No"
Names objects
Names family members
Inner language developing
Imitates words
Knows that more than one object can have label: ball, cup
Uses gestures to indicate meaning
First meaningful word: mama, dada
10 months
Dumps objects out of container
Words beginning to have meaning
Jargon to staff
Classifies meaning and sound as one: label and object are one
Communicative intent: uses sound and gestures to indicate desires
Imitates novel action with objects
Anticipates actions represented by object: coat, bottle
Babblings become "words"
Actions and objects classified and associated: eating, sleeping, going out
Associates sounds with experiences: objects have shared meaning. "Ba" means drink to infant and mom
Mutual imitation of existing repertoire of sounds
Uses other person to make things happen
8 months
Searches for object if sees where it is hidden
Imitates action modeled
Predicts simple movement of objects
Syllabic babbling using phonemes
6 months
Examines objects and people
Imitates gesture modeled through gradual approximately
Responds vocally when spoken to
Imitation of intonation
Specialized sounds to indicate emotion
Makes a motion to get adult to repeat an action
Babbling using vowel sounds made with the front of the mouth (o,u) consonant sounds using the back of the mouth (k,g)
5 months
Performs some action in response to adults action, but does not imitate
Reproduces interesting events in external environment: shakes rattle in a "procedure"
Finds partially hidden object
Polysyllabic sounds
Voluntary actions made with own body
4 months
Uses simple movement patterns to explore objects
Imitation of sounds: approximation
Laughs out loud
Differenciates and responds to familiar sounds: smiles at mom's voice
Grasps toy when in vision
Distinguishes environmental sounds
Smiles and vocalizes when talked to
Selective attention to sounds
Distinguishes sounds, voices
Saliva sounds are made
Attempts to keep toy in motion by repeated hand or leg movement
3 months
Takes objects to mouth
Turn head to sound
Fixates and tracks objects and people
Increased voluntary control of muscles
Birth to 6 weeks
Stimulus recall and scanning. Begins to store sensory information
Sensory intake, uses all senses to learn about the world.
Noises made are a reaction to internal stimuli: cries when hungry
Behavioral reflexes: sucking, rooting, grasping in response to external stimuli

which is being served. Such language lattices can be developed for preschool age children as well. More advanced lattices or sequences could include:

- -lexical production progression
- -lexical comprehension progression
- -production of semantic relations progressions
    - -single word usage
    - -two-word productions
    - -three-word productions
    - -complex productions
- -comprehension of relational meaning
- -production and comprehension of grammatical form
    - -sentence elaboration
    - -inflectional development
    - -interrogative usage

(Cohen and Gross, 1979)

SOCIAL/EMOTIONAL DEVELOPMENT-RATIONALE

The development of social relationships is probably most closely tied to the parallel development of cognitive constructs. But it is also intertwined with increased differenciation of motor skills which enables more complex and volitional interpersonal interaction. Increased language comprehension and expression also enhances higher level social interchange.

The impact of delays or deviations in emotional development may have compounding effects on the skills acquistion in other areas. A child who is passive and withdrawn or fearful of interaction may not interact as frequently or intensely with objects and people in the environment. Both practice and generalization of motor skills and cognitive problem-solving efforts may be effected. The child who behaves impulsively and has a short attention span may have difficulty in planning sequences of movement. She/He may have unsystematic, ineffective problem-solving approaches which may later effect academic performance. Inability to see others' points of view may cause social difficulties, but probably will also be reflected in an inflexible approach to accomplishing or attaining desired goals. Emotional problems may also result in overdependence on adult assistance with a consequent delay in independence and a lack of self-confidence, risk-taking and exploration.

Language acquistion may also be impacted. The child who is socially delayed may not verbalize as frequently in interactive situations. Play with language - manipulation and experimentation with vocabulary, grammar, syntax- may not be fully experienced. Modeling behaviors may not be exhibited. Language may appear delayed when, in fact, the child is merely not utilizing language to the fullest extent possible. This will affect not only teacher interaction, but may also affect peer interaction, as children tend to seek out other children at their same language level (Bloom, 1974; Guralnick, 1978). The child who does not respond appropriately to directions or seems not to comprehend language may be demonstrating lack of compliance or withdrawal rather than language delays.

Observation of children's social patterns is extremely important. Unfortunately, the social/emotional area has primarily been concerned with elimination of maladaptive behavior rather than fostering the development of social sequences. Many curricula include a list of skills in the social/emotional area which are designed to "prepare" the child for academic settings. The child needs to:

-attend for 20-30 minutes

-follow three directions

-wait for his turn.

These are all important skills, but need to be addressed within a developmental framework. Children with emotional problems or delayed social development may not be able to perform at the same social level as they are capable of performing at the cognitive level. For instance, cooperative efforts and games with rules may be too difficult for a child still at the level of parallel play. The significance of attachment (Bowlby, 1969; Ainsworth, 1973; Klaus and Kennel, 1976); separation (Ainsworth, 1973; Bowlby, 1973; Mahler, 1975); individuation (Mahler, 1975) are becoming increasingly apparent to professionals working with young handicapped children (Foley, 1980). The relationship of play behaviors to the development of social and emotional, cognitive, language and motor skills (Garvey, 1977) is recognized and is particularly important for handicapped children (Linder, 1980).

The following suggested sub-areas of social/emotional development focus on progressions which take into consideration these precursors to healthy emotional development and appropriate and responsible social interactions. The lack of certain sub-skills (e.g. cuddling) may indicate a concern which has implications for another area of development (e.g. motor). The intervention may not be to "train" the skill, but to raise the level of awareness in the family and team about the social impact of the lack of these behaviors. Also interventions which will optimize opportunities for pleasurable interaction (e.g. positioning) would be indicated.

SOCIAL/EMOTIONAL SEQUENCES

-indiscriminate social responsiveness
    -signalling behaviors
        -crying progression
        -smiling progression
        -vocalizing progression
-differential social response
        -to face
        -to patterns
        -to parent
-contact seeking/formation of dependence relationship
        -indication of preference for mother/differentiation of strangers
        -indication needs progression
        -fear of strangers progression
        -response to separation
-differenciation of self
        -reaction to mirror image progression
        -exploration of others

        - -reference to self
        - -identifies self in picture
        - -sees others perspective
        - -knows sex
    - -establishment of independent activities
        - -locomotion progression
        - -manipulation of objects progression
        - -plays near adults
        - -explores expanding environment progression
    - -goal directed interaction
        - -plays by self
        - -object use progression (cognitive)
        - -parallel play progression
        - -on-looker behavior
        - -cooperative play progression
        - -sharing progression
        - -awareness of emotions progression
        - -dramatic play progression

The development of checklists or lattices of important progressions will allow staff to observe children and determine their level of interactive skill. It is important to emphasize, however, the interrelated nature of development. As has been previously discussed, each area of development effects every other area. The staff need to be aware of this in their observations in order to avoid misinterpreting observational information. The team approach should help circumvent this pitfall.

Once the specific needs of the children in each developmental area have been identified, the staff can begin the search for appropriate curricula. The greater the developmental delays, the greater will be the need for sequences with discrete breakdowns and progressions with smaller "steps" in between. The activities recommended can also be analyzed to determine whether they are the most appropriate. The greater the abilities of the child, the more need there is for integrated, experiencial programs. Activities should provide for optimal challenge and a degree of novelty (Furth and Wachs, 1975).

CONSIDERATIONS FOR GIFTED HANDICAPPED

It should not be assumed that every handicapped child will be delayed in all areas. Every child has strengths and weaknesses. Many normal and gifted children have handicaps yet can function at above average levels in cognitive and other developmental areas. Provisions need to be made to provide for advanced level activities for these children. For example, physically handicapped, emotionally distrubed or language impaired chidlren may also be very bright. Programs can be individualized so that areas of deficit are addressed as well as providing advanced work in apporpriate areas. Enrichment activities in drama, art, and music are important for all children and should be included in the curriculum. For gifted handicapped, opportunities to develop creative talents in the visual and performing arts can provide a needed boost to self concept as well as provide a means to capitalize on abilities.

Curricula for the handicapped need to be broad and encompass developmental, skill, and enrichment areas. They also need depth, so as to be able to meet the individual needs of a great variety of children with a wide range of abilities.

UTILIZATION OF CURRICULA

Curricula may be utilized in a variety of ways. They may be followed like a "bible," adopted as a guide for planning, used as a supplement to an existing program, or serve as a resource for new ideas. The manner in which any set of curricula are operationalized should be reflective of program philosophy.

The previous discussion has focused on curriculum content and variations of presentation of content. Two other considerations, structure and methodology are germaine to the utilization of curricula.

STRUCTURE

Included in the structure is:

1) the amount of time allocated to content areas
2) the amount of time spent in functional versus structured practice activities
3) the amount of time devoted to purposeful integration of developmenal areas
4) the amount of "free time" versus facilitated play
5) the role of the environment
6) the role of the staff
7) the role of the child
8) the role of the parent

Examination of each of these elements will reveal why different programs which have adopted the same curriculum may function in extremely diverse ways.

1) Time Allocated to Content Areas

The amount of time given to each content area of the curriculum is one indication of the relative priority of that area. Table II gives examples of three daily schedules from different programs. An examination of the three daily schedules may show a high percentage of the day may be devoted to one area of development (See Table III, A). Of course, in any one activity there are many developmental areas involved, but the area which is targeted from the curriculum is emphasized. In a program using primarily a cognitively oriented curriculum, (Program I, Table II), for example, one would expect to find a high percentage of the day devoted to cognitive and language development. Program II has time allotted for group activities which will emphasize language development. Program III, which emphasizes individual work with children in each of the development areas, attempts to balance the program across all areas.

Table II

DAILY SCHEDULES - PRESCHOOL

	Program I	Program II	Program III
8:30-8:45	Child Planning time (cognitive, language) ++ oo	Circle time-Names (language) + o	Free time (cognition time motor sequence) ++ oo*
8:45-9:00	Block Play (cognitive, fine motor, social emotional) ++ oo**	Puzzles, etc. (fine motor, cognition) + oo	Individual Cognitive targets + o
9:00-9:20	House play (cognitive, language, social/emotional) ++ oo**	Labeling Pictures (language) + o	Individual language targets + o
9:25-9:50	Sharing time (language, social/emotional) + oo	Drawing Pictures (fine motor) ++ o	Individual fine motor targets + o
9:50-10:15	Snack time/potty (self-help, language, cognition) ++oo	Snack/potty (self-help) ++ o	Snack/potty Individual feeding, toileting targets (self-help) ++ o
10:15-10:35	Small group work (cognitive, fine motor) + oo	Obstacle Course (gross motor, language) + oo	Group game (social/emotional, gross motor) ++ oo
10:35-10:55	Recess-outdoor play (gross motor, social/emotional) ++ oo **	Story time (language) ++ oo	Individual gross motor target + o
11:00-11:20	Story time (language cognition) ++ oo	Music (langauge) ++ oo	Free time (cognitive, fine motor, social/emotional) ++ oo*
11:20-11:40	Art or Building (cognitive, fine motor) ++ oo**	Group games (gross motor, social/emotional) ++ oo**	Directed finger painting (sensori motor) + o
11:40-12:00	Clean-up, home (self-help, motor) ++ oo	Clean-up, home (self-help) ++ o	Dress-home (self-help) + o

2) Practice time vs. Functional time

The analysis of time spent in practicing skills in drill-type activities versus practicing skills through application in functional activities is another measure of program difference (Table III, B). In Program I, the philosophy is one in which staff believe learning takes place best when children practice skills in functional settings. Therefore, 80% of the child's time is spent in informal play activities. Program II puts more emphasis on directed skill practice than Program I. Staff feel that the children need some guided practice to bring them to a functional level, but 60% of the day is spent in application of skills. Program III spends the greater portion of the day in directed skill practice. Each child's individual targets are worked on. Functional application of skills take place in free time, snack time, and group games.

3) Integrated vs. Segregated time

Another indication of how a curriculum is being utilized is the amount of time in activities which focus on integrating areas of development (Table III, C). Many programs will set aside time to work on specific curriculum areas such as language or fine motor skills (Programs II and III, with 70% of non-integrated activities). Other areas of development may be needed in order to accomplish the activity, but the staff does not purposefully extend the activity to skills in other developmental areas. For example, in an activity designed to practice action verbs using objects that move, the teacher will focus on producing the appropriate verb form and will move to the next child or next object when the correct answer is given. In a developmentally integrated program, the teacher might incorporate cognitive skills as well by asking classification questions about what other object is the same shape, is the same color, or has the same function. The teacher might incorporate motor

Table III

DAILY SCHEDULES - PRESCHOOL

A. % of Activities Targeting Development Areas: (See Table II)

Program I	Program II	Program III
Cognition-60%	Cognition-10%	Cognition-30%
Language-50%	Language-50%	Language-10%
Fine Motor-20%	Fine Motor-20%	Fine Motor-20%
Gross Motor-10%	Gross Motor-20%	Gross Motor-20%
Self-Help-20%	Self-Help-20%	Self-Help-20%
Social/emotional-40%	Social/emotional-10%	Social/emotional-30%
		Sensorimotor-10%

B. % of Functional Activities vs. Practice Activities: (See Table II)

Program I	Program II	Program III
++ Functional-80%	++ Functional-60%	++ Functional-40%
+ Practice-20%	+ Practice-40%	+ Practice-60%

C. % of Activities Purposefully Integrating Development Areas: (See Table II)

Program I	Program II	Program III
oo Purposeful integration-100%	oo Purposeful integration-30%	oo Purposeful integration-30%
o Single Area or incidental integration-0%	o Single Area or incidental integration-70%	o Single Area or incidental integration-70%

D. % of Free Time vs. Facilitated Play: (See Table II)

Program I	Program II	Program III
** Facilitated Play-40%	** Facilitated Play-10%	** Facilitated Play-0%
* Free time-0%	* Free time-0%	* Free time-20%

skills by having the child demonstrate use of the object in a variety of ways or might provide the opportunity for social interaction by having two children utilize the object together.

Segregated activities have the advantage of being focused. Consequently, it is easier to count correct responses to reach criterion on a specific skill. When working with a group of children, it is less taxing on the teacher to keep in mind the objectives for those children in just one area of development. On the other hand, most activities that the child performs independently incorporate a variety of skills. It is more functional for the child to experience these interrelationships in school activities as it may facilitate transfer of learning to other situations.

The typical curriculum is divided into sections for each developmental area. This segregated approach has encouraged fragmented teaching of skills, and the viewing of children in parts rather than as a whole. As the team concept of working with handicapped children becomes more accepted, an increase in purposefully integrated program activities will probably be seen. Even for the severely involved child who is working on practicing a specific skill, incorporation of other program areas can be accomplished. By working on a skill in a variety of ways, in multiple settings, in combination with other skills, the child will learn to generalize. Thus the skill becomes functional.

Integration of program areas, whether in skill practice activities or functional activities requires familiarity with each child's total program plan and preparation time to organize composite activities. Staff need time to plan as a team to determine the relative time priorities for each content area, for skill practice, functional application and integration for each individual child. The amount of time each member of the team will allocate to individual and group time will have to be determined.

4) Free Time vs. Facilitated Play

The importance of play to the normally developing child is now well accepted (Piaget, 1962, 1962a, 1973). Social emotional development, language, motor and cognitive development are all enhanced through play activities (Garvey, 1977; Weikart, Epstein, Schweinart and Bond, 1971). The benefits of play to the handicapped child are also recognized (Shores, Hester, and Struin, 1976; Devoney, Guralnick, and Rubin, 1974). Play experiences for the handicapped child, however, may need more guidance and facilitation, depending on the child's handicaps, degree of impairment, and developmental level. Programs vary in the amount of time they allow for play. They also vary in the degree to which play is an actual part of the curriculum. Some programs will allow "free time" for children to do whatever they wish with the toys in the room (as in Program III). Others set up specific areas with selected toys to encourage appropriate skill practice (Program I). In programs where play is an integral part of the curriculum, staff will facilitate appropriate interaction, exploration, manipulation and language usage.

Is is recommended that staff examine their use of "free time" to determine how play can become an intrisic part of the curriculum rather than a peripheral or enrichment part of the day.

5) Structure of the Environment

Regardless of the curriculum chosen the environment plays a key role. The difference lies in the way environment is structured for the children. Some curricula describe environments and activities which are facilitative of interaction. That is, toys, settings, and materials are made available to the child. They may even be intentionally arranged in such a way as to promote a specific type of involvement. For example, a play house may be set up with pots hanging in a sequence from large to small on their matching shaded silhouettes. This arrangement encourages and facilitates practice with matching and size sequencing when the child hangs the pots back up. The child chooses to play with the materials and is not necessarily corrected for not responding with the right sequence. The environment may be structured in such a way that correct responses are virtually assured. Montessori shape and size cylinders are examples of self-correcting materials. The pieces only fit properly in specific holes. The more structured the environment becomes, the more shaping of responses takes place. The number of choices of stimuli the child has is reduced, the time allowed for stimulating a response becomes more definite, and the degree of specificity of response becomes more precise.

6) Role of the Staff

The role of the staff is directly related to the environment, as the staff are the organizers of the environment. They determine the choice of materials, the arrangement, the sequence and manner of presentation of materials, and the consequences for specific responses to the materials. The staff can play a facilitative role by providing opportunities for the child's interaction with the structured environment. They may also play a therapy or "training" role by structuring the environment to such a degree as to ensure a successful response, thus shaping desired behaviors. Of course there are combinations of approaches, but curricula tend to promote a certain degree of structuring of environment throughout. Any curriculum can be modified as is deemed necessay for a particular population or specific child, however, the role of the teacher in effectively structuring the environment is a key variable.

7) Role of the Child

The role of the child as discussed in Chapter 3 depends to a great extent on the structure of the environment and the role of the staff. When staff see themselves as facilitators, structuring experiences, then the child will have a more active role in the course of his own learning. The child will be able to select activities and skills that are appealing to him/her and will have a broader range of acceptable responses within any one activity. When staff perceive of themselves as trainers of specific skills, then the child will have less of a self-determining role. She/He will be placed in the position of receptor of selective stimuli to ensure successful interaction at an appropriate level.

8) Role of the Parent

Depending on the program philosphy the parent may have varying degrees of involvement in the child's education. As it is important to include the parent as much as possible, the curriculum should be analyzed for adaptability for use by parents. Is the parent's role to be one of facilitator or trainer? The answer to this question will determine the type of suggestions or programs that will go home. Activities should be adaptable to home environments and not require specific equipment or skills, unless that equipment and skill training are provided to the parents (See Chapter 7).

METHODOLOGY

The methodology is closely intertwined with program structure. Elements of methodology which relate to curriculum utilization include:

1) source of activity initiation
2) primary relationships
3) motivational factors
4) materials usage and sequence of presentation
5) measurement of desired outcomes
6) behavior management

A further analysis of each of these factors will serve to further illustrate how curriculum utilization may vary.

1) Source of activity initiation

Activities are either child-initiated or adult-initiated. As previously mentioned, the role of the child in the environmental structure can be active or more passive. The program that allows children to choose their activities and interactions will use different teaching techniques than those programs where the adult selects and initiates interactions. In child-initiated activities the teacher may ask questions, focus attention on specific aspects of a problem or situation, make comparisons, or suggest solutions to problems. The parameters of the situation are broad, as the teacher can facilitate any number of interactions. Astute observational skills are necessary to perceive opportunities for learning needed skills, and creativity is necessary to be able to make the most out of every event. Adult-initiated activities on the other hand are more focused in their objectives and means for achieving desired results are clearly outlined. Planned activities incorporate the teachers selection of materials, methods and outcomes.

2) Primary relationships

Child-initiated activities have as a philosophical justification the importance of the development of independence, social interaction and problem-solving. Learning takes place through manipulation, experimentation and imitation. The primary relationships are thus child-environment interactions and child-child interactions which allow for maximum learning opportunities. Adult-initiated activities place more importance on the relationship between the teacher and child. Manipulation, experimentation, and imitation are still important but the environmental stimuli are selected and presented by the teacher. The adult rather than peers becomes the source of learning. Prompting, cueing, shaping, modeling and scheduling of reinforcement are controlled by the teacher. The teacher may use some of these techniques in child-initiated activities, but the approach is more informal and less structured.

3) Motivational factors

There are probably internally and externally reinforcing factors involved in every task. However, the degree to which a program adopts specific external reinforcement procedures to promote desired responses may differenciate one program from another. For example, two children in two different programs may have the same goal from the same curriculum guide. "The child recognizes and uses adjectives which describe properties that can be discriminated by touch". (From Learning Staircase, copyright, 1976 by Lila Coughran and Marilyn Goff, Teaching Resources Corporation, Boston, Mass.). In the program this objective might be taught by arranging a tactility stimulating environment and then observing the child in play and asking questions about the object's characteristic, "Is the block hard? Is it smooth?" In another program, the teacher may arrange a variety of objects with specific tactile characteristics and demonstrate characteristics by comparison and modeling. "Feel, these are smooth. These are rough." The response to, "How does this one feel?" may be reinforced for accuracy. The question may be asked a set number of times in relation to various objects until the child has successfully responded enough times to meet criterion for that objective. In the first example, the involvement with the environment may provide the motivation for learning; while in the later case, the reinforcement from the teacher may provide the primary motivation for learning.

4) Materials usage

The type and usage of materials is directly related to the above elements. Materials employed in a program or made available to the child and how those materials are presented will vary from program to program. First of all, what type of materials are available, when are the materials available, how are materials utilized? Some programs have sets of materials for teaching specific objectives and other toys and materials for play experiences. Others have a variety of materials available which are utilized both in teaching and in play. It is recommended that for purposes of skill generalization, functionality, and the development of exploratory behaviors that the following be considered:

a) have a variety of toys and materials available for specific objectives,

b) utilize materials also found in the home,

c) utilize materials that can be used in many different ways,

d) utilize materials that are developmentally appropriate,

e) encourage children to manipulate, explore, and utilize materials in non-conventional ways, without adult direction.

5) Measurement of desired outcomes

The measurement of child progress is a requirement of all programs serving young handicapped children. As designated in P.L. 94-142, each child served must have written goals and objectives. The methods of documentation employed varies from program to program.

a) Anecdotal records, or brief narratives, may be kept on individual children in relation to specific objectives. Programs may also use this method of documentation as a supplement to other measurement techniques.

b) Checklists. Lists of objectives or skills may be utilized in pre/post measurement at the beginning and end of the year or on an intermittent or continuous basis. The spacing and range of developmental increments (small or large) and nature of the population served (severity) will determine how the checklists are used.

Objective	Entry Behavior	Date Acheived
Names three colors on request	+	10/15/80
Names three shapes ○, □ and △	—	

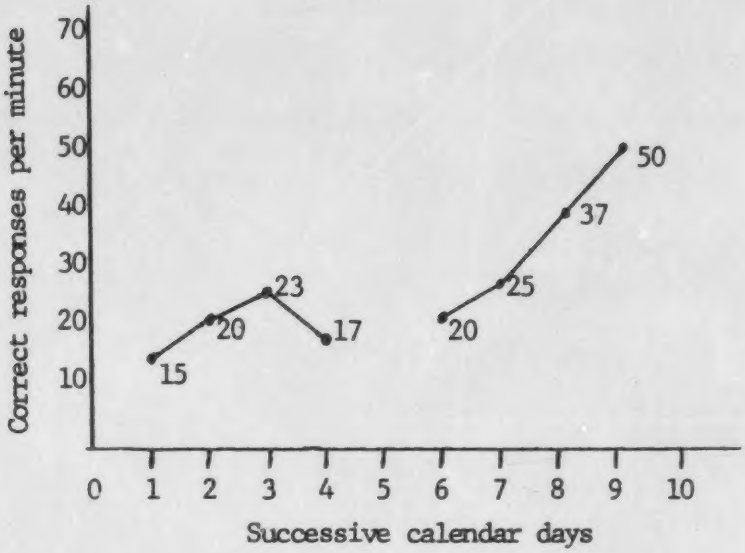
c) Probes are devises used over a period of time to sample behaviors and assess change. White and Haring (1976) identify certain elements of change which may be measured:

-topography, or behavior sequence
-force, or magnitude of the behavior
-locus, the direction or target of charge
-duration, or amount of time engaged in a behavior
-latency, or the time between behaviors
-frequency, or rate of change

Probes can assess change in any of the above using such methods as:

-frequency of rate counts
-percentage statements
-ratio statements
-criterion measures

d) Charting or graphing the probes may be done on a regular basis to illustrate progress.



The frequency, percentage, or ration may be stated on the vertical axis, and the probe period on the horizontal axis. Such graphs provide information on rate of growth as well as amount of growth. Behavorially oriented programs tend to imploy such measurement techniques.

e) Criterion referenced tests may also be used as a probe to assess growth in relation to stated objectives (See page 170). The rate of growth can also be recorded.

Objective	Criterion	Begin	Accomplished
Names four objects - cup, ball, baby, shoe - When presented with real object	3 of 4	2/10/80	2/20/80

Crite[illegible]n referenced tests can be used as ongoing or pre-post measures.

f) Standardized testing can also be used to measure growth from one period of time until another (See Chapter 5). Normal testing is usually utilized along with other measures.

The type of curriculum a program uses and the philosophy in relation to structure and methodology will determine the type of measurement which will be adopted. Measurement should be ongoing and measure the functionality of skills as well as the accomplishment of skills in specific situations.

6) Behavior management

Another aspect of methodology which varies across programs is behavior management. Depending on the philosophical basis of the program, different techniques may be utilized. Hallahan and Kaufman (1978) describe the most common approaches:

-the psychoanalytic approach which relies on psychotherapy for child and parents.

-the psychoeducational approach which emphasizes meeting individual needs of the child through educational and developmentally appropriate techniques.

-the humanistic approach which emphasizes a non-authoritarian, open, personal atmosphere.

-ecological approach which involves all aspects of a child's life, including classroom, family, neighborhood, and community in teaching social skills.

-behavioral approach which involves measurement of responses and subsequent analysis of behaviors in order to change them. Emphasis is on reinforcement for appropriate behaviors.

As with other areas of the program, the behavior management techniques utilized tend to be consistent with other aspects of program structure and metholodology. Programs need to determine what approach is most appropriate for the population being served.

RECOMMENDATIONS

The program staff need to plan carefully not only what curricula will be adopted but how the curricula will be used. The following are additional questions for staff consideration in selecting curriculum materials:

1. For which development levels are the programs appropriate? Curricula should be broad enough in range to meet the needs of both the lowest functioning and highest functioning child in the population to be served. More than one curriculum may be necessary.
2. What skills does the program teach? Skills addressed in the curriculum should reflect needs identified in the assessment process.
3. Is the scope and sequence appropriate to the population? For severely involved populations specific content areas might need to include specific developmental sequences in feeding, dressing, toileting, etc. Developmental progressions may need to be highly discrete. For higher functioning populations broad curriculum areas which contain sequences in language, cognition, gross motor, fine motor, and social/emotional may be adequate. The type of sequence is important as well. Task analysis provided in some curricula are not developmentally sequenced. For instance, a motor task analysis resulting in the objective "Child can stand on one foot for 10 seconds" may break down

    Stands on one foot for one second.
    Stands on one foot for two seconds.
    Stands on one foot for three seconds.
    Stands on one foot for four seconds.
    etc. . . . .

This task analysis does not take into account developmental prerequisites and sequences. A more developmental sequence might include

balance in sitting
balance in standing
moves from standing to sitting without falling
stoops to retrieve objects from standing position
walks steadily
walks up and down stairs with assistance
walks up and down stairs without assistance

Reflexive integration and appropriate body reactions, such as protective and righting reactions would be important.

4. How are the activities written? Many curricula are geared to specific disciplines and assume an understanding of terminology and "jargon" which may be meaningless to parents or lay persons involved in the program. The degree of specificity used to describe activities may also be important. Greater detail may be needed by parents, lay persons, or other discipliners unfamiliar with specific techniques or methods.

5. For what types of handicapping conditions is this curriculum appropriate or inappropriate? An activity usually requires input on the part of the child and/or the teacher and output of some sort on the part of the child. If visual, tactile, auditory channels are heavily emphasized in a curriculum, the visually impaired, motorically involved, or auditorily impaired child may not be able to adequately receive information in order to process it. Similarly, if specific verbal or motoric responses are demanded in response to an activity, the child who is handicapped in these areas may experience a great deal of frustration. If activities are primarily geared

to individual or group discovery approaches, the severely involved child may end up watching other children, or engaging in non-productive or destructive activities. If the activities require a high degree of didactic instruction, the children need to be cognitively capable of understanding the material and the style of presentation. Behavioral, verbal instructions, shaping, chaining procedures may be unduly limiting and educationally restrictive for a high level child. Precision teaching activities require a small staff/child ratio to be able to adequately record the child's progress.

6. What teaching techniques are promoted? Staff will need specific skills, depending on the orientation of the curriculum and how detailed the instructions are. A cognitively oriented program will operate best when staff are capable facilitators of exploration, able to ask questions to stimulate problem-solving and language production. Behaviorally oriented programs, on the other hand, will need staff with skills in cueing, shaping, reinforcing, etc.
7. What is the amount of time needed each day for use of the curriculum? Many guides cover all areas of development and are sufficiently comprehensive to provide the basis for a total days program. Others emphasize one area of development, or are inadequate for total program planning. Staff may need to utilize more than one curriculum to assure a full days activities.
8. Is the curriculum consistent with the philosophy of staff who will us it? Once again, it is important to examine the philosphical basis of the curriculum to ensure congruity with staff beliefs. Curricula may be modified and adopted, but staff need to discuss the changes that will be needed in content, methodology, and structure.

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SEVEN

PARENT INVOLVEMENT

A mother accompanies her son to his preschool class, takes off her coat and begins to play with a group of children in the corner. A father, with diaper bag under one arm and his handicapped infant under the other, struts into the classroom on Saturday. He brags to the other fathers about how his daughter is now able to sit with just a little support. The sister of one handicapped child opens their living room door and helps the developmental specialist unload all of her toys and equipment. The sister is bubbling over with information about all that has happened during the week. A group of parents sit sipping coffee and watching a video tape showing a cerebral palsied child in therapy. Afterwards the parents discuss the tape, their experiences with their own children, and their feelings about having a handicapped child.

These scenes are examples of the many ways that parents are becoming involved with their handicapped child's program. In recent years there has been a growing emphasis on parental participation in the educational process (Fredericks, Baldwin & Grove, 1974; Hofmeister & Reivis, 1974; Lillie and Trohanis, 1976; Quick, Little and Campbell, 1973; Shearer and Shearer, 1977).

This involvement has increased both as a result of the requirements of funding sources such as the federal government, but also as a consequence of research which shows the educational importance of parent involvement. Urie Bronfenbrenner (1974) stated:

"The evidence indicates that the family is the most effective and economical system for fostering and sustaining the development of the child. The evidence indicates further that the involvement of the child's family as an active participant is critical to the success of any intervention program. Without such family involvement, any effects of intervention, at least in the cognitive sphere, are likely to be ephemeral, to appear to erode once the program ends. In contrast, the involvement of parents as partners in the enterprise provides an on-going system which can reinforce the effects of the program while it is in operation, and help to sustain them after the program ends."

RATIONALE

Parent involvement in its broadest context implies shared responsibility for the child's educational process. It also implies that as a member of a dynamic family unit, the handicapped child has as much of an impact on the family as the family has on the handicapped child. It is a reciprocal relationship. The family is a critical factor in the child's environment, and thus parent involvement implies an ecological approach to handicapped children. Morrison(1978) has defined parent involvement comprehensively as the "process of actualizing the potential of parents; of helping parents discover their strengths, potentialities, and talents; and of using them for the benefit of themselves and the family" (p22).

This inclusion of the parent in the education process offers a new orientation to children and families. The reasons for a parent component in early childhood programs are numerous, and there is much research to support the efficacy of parental participation. The following benefits have been seen as a result of the active involvement of parents in early intervention programs for young handicapped children.

1. The child's home environment can become more facilitative of learning. Research has documented the importance of the years from birth to eight as being the years of most rapid intellectual growth (Bloom, 1964; Hunt, 1961). What happens to the child in his environment before the age of eight can have long-term, if not life-long, impact. Jencks et. al. (1972) has noted "children seem to be far more influenced by what happens at home than by what happens in school" (p. 255). As the parents are the child's primary teachers in the early years, it is important to help parents create an optional learning environment in the home.

Burton White studied the effects of experience and environment on children's growth and development (White and Watts, 1973). White (1975) concluded:

> "In our studies we were not only impressed by what some children could achieve during the first years, but also by the fact that the child's own family seemed so obviously central to the outcome. Indeed, we came to believe that the informal education that families provide for their children makes more of an impact on a child's total educational development than the formal educational system. If a family does its job well, the professional can then provide effective training...(This) is a direct conclusion from the findings of thousands of programs in remedial education, such as Head Start and Follow Through projects" (p. 4).

If the family is "so obviously central to the outcome", we cannot ignore their importance to the child's growth and development. Parents can be helped to create an optimal learning environment for their children.

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2. Parents of handicapped children need support and encouragement to effectively cope with the problems of having a hancicapped child (Boggs, 1978; Roos,(1978); Turnbull,(1978). Having a handicapped child can make the difficult job of parenting even more demanding. In addition, the parental reactions to having a handicapped child may compound the situation by making the parents emotionally unavailable to the child. Philip Roos as both a professional (1963) and a parent (1978) has described these reactions as:

- loss of self-esteem
- shame over social rejection
- ambivalence between love and anger
- depression, grief, chronic sorrow
- self-sacrifice
- defensiveness
- disillusionment with parenting
- feeling of isolation
- feeling of vulnerability or loss of control
- inequity
- insignificance
- withdrawal from future planning

Programs which offer support and encouragement to parents through counseling and parent groups have shown that such efforts result in the parents attaining greater self-confidence and the ability to solve problems relating to their own personal growth and that of their handicapped child (Arnold, Rowe and Tolbert, 1978; Johnson, 1979).

3. Parent involvement in the child's educational program provides for greater continuity and coordination of learning between school and home. If

parents and teachers exchange information about the child, the objectives which are developed will be more appropriate than those which do not take into consideration the parent's desires for the child at home. Also, if a child is learning specific skills at school these skills will be learned faster and become more functional if they are also practiced at home (Cansler, Martin and Valand, 1975; Morrison, 1978). Parents who learn how to evaluate their child's growth also have an increased understanding of their child's strengths and weaknesses as well as a better understanding of the education process (Kroth and Simpson, 1977). By involving parents in planning, implementing and evaluating their child, they gain a functional grasp of child development, an ability to work on specific skills, and the capacity to make judgments concerning appropriate activities for their child.

4. Parent education can provide opportunities for parents to gain information which will allow them to improve their interactions with their handicapped child. Recent Gallup poll (1976) surveys have shown that a majority of parents feel they could benefit from parent education. For parents of handicapped children this need is often magnified. Programs for young handicapped children have found that parents want information on such topics as:

-normal child development

-childrearing practices and behavior management

-knowledge about handicapping conditions

-intervention techniques for their child

-community resources

-advocacy issues

(Cansler, et.al., 1975; Klein, et.al., 1978; Lane, 1975; Lillie and Trohanis, 1976; Quick, et.al., 1973). By providing a variety of informational alternatives, parent education can be individualized to meet specific needs of families.

5. Parent involvement can help parents to become aware of and learn how to use existing community resources. The service delivery system for handicapped children is fragmented and difficult to understand. For a parent, the "system" can be overwhelming and even contradictory (Selig, 1976). The agency providing services to young handicapped children can serve as case manager for services to families involved in the program. Monitoring service delivery is important not only to ensure that the child and families needs are met, but also to ensure that consistent efforts are made.

For example, a welfare mother who needs help in developing parenting skills may be encouraged by school staff to work with her handicapped child at home, attend therapy sessions with the child and also be part of a parent group. This same woman may have a social services case worker who is encouraging the mother to find employment. The resulting conflicts felt by the parent regarding her responsibilities to care for her child and yet also earn an income may render the mother so anxious as to be ineffectual in either role. The staff working with the family should be aware of all other services being provided, the nature of these services, and work toward coordinating and maximizing their effectiveness (Selig, 1976).

6. Parent involvement in planning and decision-making ensures that needs are addressed at all levels of the program. When parents help make decisions regarding their child's individual program plan, they are more likely to comply with requests from the staff. When parents contribute to decisions regarding the content of the newsletter, the speakers for a class, the guidelines for classroom participation or numerous other activities, the results will be more meaningful to other parents. Parents have the best insights into the needs of other parents. Parent involvement in the decision-making processes is crucial to active, on-going interest in the program (Powell, 1979).

7. Another reason for parent involvement relates to economics. By utilizing parent volunteers the cost of the program can be reduced (Stile, Cole and Garner, 1978). The smaller the ratio of adults to children, the more individualized the program can be. Parent volunteers can work directly with children or assist with data collection and evaluation allowing more time for staff to work with children. Parents can also help with record keeping, making materials and showing visitors around the center. Parents working with other parents can also be effective (Smith, 1980). Parent involvement can thus provide needed human resources to expand the quantity and quality of services which are provided.

8. Parent involvement builds community support for early intervention programs. Parents who have observed their children's program and have been involved in working closely with staff to provide follow-through at home have a better understanding of the goals and objectives of the total program and the means by which these objectives are accomplished. Parents who have been helped through difficult emotional periods to cope with the stresses of having a handicapped child, have a better understanding of the support systems which early intervention programs provide. Parents who have acquired better parenting skills and improved their interactions with their handicapped child and other children in the family have a better understanding of the benefits the programs offer to families as a unit. Parents who understand these benefits will support program continuation and the development of other needed services. As consumers parents will speak out and demand the best expenditure of their tax dollars. Parents as program advocates and liaisons to other organizations and groups are vitally important.

All of the benefits which are delineated above are inherent in purposes of parent involvement designated by Morrison (1978).

1. To promote the comprehensive development of children.

2. To enhance the role of the parent as the primary educator and care-giver of the child.
3. To help parents develop and use knowledge and skills which will enhance the lives of families.

THE FAMILY AS A SYSTEM

In working with handicapped children, staff must recognize that in order to be most effective they must consider the needs of the family as a system. As with any system there are many interrelational facets.

"Each family must be recognized as a unique system, with individual differences in its patterns of interaction, assignment of roles, developmental aspects, cultural orientation, environmental conditions, emotional climate and satisfaction of needs" (Klein, et al, 1978, p.33).

Families may vary in the manner in which they interact. Some families are very close, with strong mutual support systems within the nuclear family. Other families rely on extended family or outside support systems such as neighbors or friends. Communication within the family may range from being open, direct and honest to closed, self-concealing or misrepresentational. Staff need to assess the interaction patterns, levels and types of interactions to ascertain how best to communicate with all family members.

The assignment of roles within the family system is also important. Roles within the home environment concerning housekeeping duties, parenting responsibilities, discipline, child care, etc. reveal on-going burdens and stresses as well as authority lines. The added responsibility of a handicapped child may throw the traditional family homeostasis off balance. Individual family roles may need to be modified to take into consideration the additional responsibilities necessitated by the handicapped child.

Families also vary in their stage of family development. Barnard and Erickson (1976) state that role changes occur in different stages:

1. Families with no children
2. Families with infant children
3. Families with preschool children
4. Families with elementary school children
5. Families with junior high school and high school children
6. Families with college age children
7. Families whose children have left home or married (p.38).

Growth and development of children influence roles. A handicapped child may not move through the normal patterns, and consequently, parents may get "stuck" in one developmental family level, one where more dependency is characteristic. Families may need assistance to move along in a normal cycle.

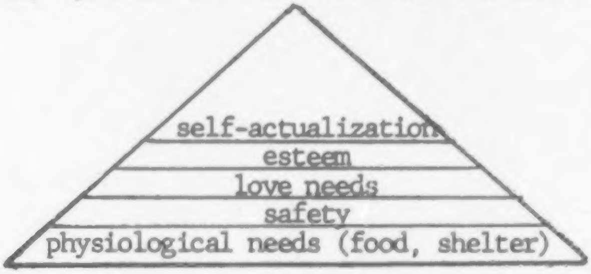
Brown (1978) has described different developmental phases in family life.

1. Establishing Basic Commitment. Both partners disestablish from their families of origin and establish a commitment to each other.
2. Creating a system for mutual nurtrance. Family structures are established for mutual support. Reciprocal nurturance is key.
3. Defining mechanisms for mutual encouragement of individuation and autonomy. Members of the family encourage individual initiative and exploration of personal goals.
4. Facilitating ego mastery. Establishing positive identity in the various family roles.

The presence of a handicapped child may cause difficulty with mastery of the tasks of each phase. Regression to earlier phases may occur. For example, the handicapped child may interfere with positive self-concept, may disrupt the existing support system, and may, in fact, threaten a couple's basic commitment to each other. Staff may be able to help families work through these stages once again.

Cultural orientations also have an effect on attitudes towards handicapping conditions, as do religious beliefs. These divergent values should be recognized as contributing toward the family's ability to cope with the stresses associated with having a handicapped child.

The emotional climate and satisfactions of needs are also important influences on the family system. Maslow's well known hierarchy of needs (1954) is relevant here.



Individual family members may be at varying levels of satisfying their needs. A family at the level of needing to assure continuing food and shelter may not see the provision of love and attention to a handicapped child as a priority. The presence of the handicapped child may also magnify an existing need. For example, a mother with a need to establish self-esteem in her career role, may have an additional need for self-esteem as a "good" parent to her handicapped child.

The family as a system also must relate to a variety of other complex systems, including the neighborhood, community, society, the economy and the school system. Arnold (1978) has pointed out that "input from any of these other systems or intervention within the parent-child system by doing or saying something to parents tends to have far-reaching reverberations throughout the parent-child system and other affiliated systems. Systems guidance makes use of this understanding by choosing points of intervention that are most likely to initiate constructive reverberation and by keeping in mind the likelihood of other components affecting the component being considered" (p.55).

THE EFFECT OF A HANDICAPPED CHILD ON THE FAMILY SYSTEM

Having a handicapped child affects the family system. Exactly how the child will impact upon the family depends on many variables, including- the nature and severity of the handicap, the emotional climate within the family, the resources the family has to bring to bear on the problem, how the family defines the problems related to the child, and the values within the family.

Research has revealed that many parents experience similar feelings when they discover that they have a handicapped child. Rosen (1955) has described five stages that many parents go through:

1. Awareness that a serious problem exists. During this initial stage, parents may feel shock, grief, fear, guilt.
2. Recognition of what the problem means. This is a period of trying to understand the handicap and what it implies for the child and for the family.
3. Search for the cause. In the attempt to ascertain the etiology of the handicap, the parent hopes for the discovery of a cure and a relief from the feelings of guilt for perhaps having "caused" the handicap.
4. Search for a solution. The parents may visit a variety of doctors, schools, or therapists in an effort to find a more hopeful diagnosis or a better remedial program.

Elizabeth Kubler - Ross in On Death and Dying (1969) identifies stages of mourning one goes through when one is dying or experiencing the death of a loved one. Parents of handicapped children have stated that they have passed through similar stages in mourning the loss of the expected normal child and the birth of a handicapped child.

First Stage: DENIAL AND ISOLATION. During this stage disbelief is predominant and there is a refusal to accept the diagnosis. At the same time, the parent may withdraw from friends and family and refuse to engage in social events. At this time parents must deal with the guilt of why the child is handicapped. Mothers in particular worry that they didn't take good enough care of themselves during pregnancy. Others feel the child is punishment for previous sins. Both parents may search their family histories for evidence of similar problems which might show genetic causality.

There is also a sense of shame about the child. How will the relatives react? Other siblings? The neighbors? The isolation of the parents is partially a withdrawal from the questions about the child which will inevitably arise. Our children are an extension of ourselves, and the birth of a handicapped child often makes parents feel that they have failed or that they are in some way inadequate or less than perfect themselves. Parents dream and plan for nine months (or longer) about the child--who it will look like, its sex, its characteristics, what it will be when it grows up. The birth of a handicapped child is the death of the hoped for perfect child. It is natural that this loss should be mourned.

Fear is also experienced in this first state. As the parents think about the future, the questions about the meaning of the handicap loom large. What does this mean to me and my other children? Will there be large medical bills? Will the child be able to do the things other children do? Will he/she be able to go to college? What will happen to the child if something happens to me?

Guilt, shame, fear are all very natural feelings and the period of denial and isolation allows the parents time to think and mobilize other defenses. At this time, they need to be supported and helped to understand that the feelings they are experiencing are not abnormal. Often talking to other parents of similarly handicapped children is helpful at this time, as other parents can identify with the pain and sorrow that the parents are feeling.

Second Stage: ANGER. It is also not uncommon for parents to feel anger. Anger is often paired with a sense of unjustness. The parents may lash out at many different targets. They may blame God, the doctors and nurses. They may find fault with the doctor for prenatal care or the delivery procedures or not telling them about the handicap in a sensitive manner. Anger may also be more indirect. A parent may begin to yell at the other children in the family or the spouse for very insignificant reasons. Anger may also be turned inward and the parent may experience feelings of self-hatred. Professionals need to recognize this anger as a natural feeling and not internalize it or take it personally. Listening to the parent and allowing time for ventilation is important.

Third Stage: BARGAINING. Bargaining often takes place with God. "If you'll just cure her or make her walk, I'll give a big donation to the church." Parents may expend all their energy working with the child. They may sacrifice their own goals in an attempt to make the child "better". It is as if they want to trade their own growth and development in exchange for that of the child. The parent may also feel that such self-sacrifice is needed as a subconscious wish for punishment. Professionals working with parents at this stage need to help parents focus on their own needs as well as those of their child.

Fourth Stage: DEPRESSION. As the weight of the meaning of the child's handicap begins to become totally appreciated, it is natural for the parent to feel greatly depressed. Often they feel conflicting feelings of love and hatred for the child. They may even wish the child dead - and then feel guilt for thinking that thought. Depression recurs. These times of depression may come and go, but seem to be intensified after an experience or observation of a small or large moment of joy in life. For example, depression may occur when a parent observes the neighborhood children all dressed up and happily racing off for the first day of school; or when they attend a friend's child's graduation or wedding. Such events point out the discrepancies between what normal children have and what the future holds for their child. Every parent wants to feel pride in their child's accomplishments and share moments of happiness. For the parents of the handicapped child, these moments may be few and far between. Olshansky (1962) has described this recurring depression and sadness as "chronic sorrow". He states that this sorrow is present throughout the child's life. Professionals need to understand these normal periods of depression, the chronic sorrow, and be able to help the parents to share joyful moments with their child and to point out the strengths and accomplishments the child makes.

Fifth Stage: ACCEPTANCE. It is questionable whether any parent of a handicapped child ever totally "accepts" their child's handicap(or whether they even should). However, parents are able to work through their feelings and come to a level of understanding of the child's strengths and limitations. They can come to have realistic expectations for the future, and they can learn how to cope with each new problem systematically as it arises. Professionals should not expect that parents will work through their feelings to the point of always being positive. Depression, anger, guilt,shame, uncertainty, sorrow will recur. Parents learn how to bear them. The professional needs to be there to support, encourage, provide direction and hope. It is an important role which demands much skill and perserverance.

"To learn how to bear the inevitable sorrow is not easily done. I can look back on it now, the lesson learned, and see the steps; but when I was taking them they were hard indeed, each apparently insurmountable. For in addition to the practical problem of how to protect the child's life, which may last beyond the parent's, there is the problem of one's own self in misery. All the brightness of life is gone, the pride in parenthood. There is more than pride gone, there is an actual sense of one's life being cut off in the child. The stream of the generation is stopped. Death would be far easier to bear, for death is final. What was is no more. How often did I cry out in my heart that it would be better if my child died! If that shocks you who have not known, it will not shock those of you who do know. I would have welcomed death for my child and would still welcome it, for then she would be finally safe".

from The Child Who Never Grew
by Pearl S. Buck (1950)

CONSIDERATIONS IN WORKING WITH FAMILY SYSTEMS

Johnson (1979) suggests that a family-centered approach should be utilized in working with handicapped children. "Family-systems theory views the family as an interacting, reacting system which is delicately balanced and struggles to maintain that balance. A change or problem in one member of the system, thus, affects the entire system" (pp. 285-286).

As previously discussed, the addition of a handicapped child to the family is a change which has a significant impact on the entire family. Professionals working with young handicapped children can provide better services to the child and the family by taking into consideration some basic guidelines.

1. Communication with family members is facilitated when they feel valued and accepted. Professionals need to listen and not judge, be able to assure parents their feelings are normal, and be able to tolerate not being heard when they offer suggestions (Cansler, et al, 1975; Johnson, 1979).

2. Professionals need to be aware of societal expectations and pressures on parents

   -to transmit cultural patterns
   -to establish social adequacy
   -to teach language
   -to help the child differentiate from right or wrong
   -to conform

3. Parents who fail to discharge their cultural obligations are labeled as overprotective, rejecting, disinterested, apathetic, guilt-ridden. These

value judgments affect parents. Professionals should avoid unwarranted "diagnosing" of parents.

4. Professionals need to be aware of conflicting opinions that parents must deal with regarding their child. They must be able to help parents objectively sort through all the information from varying systems.

5. Parents view their child differently than professionals. A general background of knowledge is available to the professional, whereas parents have specific knowledge about their child. Professionals need to utilize the parents specific information and not over generalize.

6. Professionals need to be sensitive to and accept where the parents are emotionally at any one time and not expect consistent responses. Ability to listen to, empathize with, and individualize for individual family members is needed.

7. Parents need time to digest the significance of important information. They also need to understand the relevance of information to their family system.

8. Siblings in the family tend to take on the parents (particularly the mother's) attitudes toward the handicapped child in the family (Banish,1961). Professionals can affect children by helping parents cope and assisting the family in developing problem-solving skills.

9. Professionals can help families by working to educate members of the extended family and immediate community about the handicapping conditions.

10. Families need to be involved in assessing their strengths, setting goals, determining intervention methods, and evaluating success.

11. All parents need to experience a sense of adequacy in parenting. Professionals need to offer concrete suggestions to help parents feel successful with their child.

PURPOSES OF THE PARENT COMPONENT

In order to assure individualization the parent component needs to be carefully planned prior to intake of children. The inclusion of parents of handicapped children in the planning process is critical. Parents can provide a perspective that staff may not have. As the program becomes operational, parents with children in the program can become involved in on-going planning.

The intents of the parent component need to be identified. What are the purposes of parent involvement? Morrison (1978) identifies thirteen possible goals of the parent program:

1. Enchance the role of the parent as the primary educator of the child.
2. Strengthen and support the family
   -alleviate and rectify problems
   -increase ability of family to function as a unit.
3. Enchance the development of the child.
4. Prepare children for school.
5. Prevent school failure.
6. Increase parental interest in the school.
7. Utilize abilities and talents of parents.
8. Extend services of social service agencies to children.
9. Utilize a narrow focus, e.g., educate the child.
10. Utilize a comprehensive focus, e.g., a full range of health, social nutritional, and educational services to children and families.
11. Break intergenerational cycles of poverty(the original intent of Head Start).
12. Satisfy or meet federal and/or state guidelines in order to receive programmatic monies.

13. Provide employment to parents who are low income, unemployed, etc. (p. 65-66).

Many early childhood special education programs have four dimensions to their parent involvement component (Amon, Colorado Parent Book, 1978; Lillie and Trohanis, 1976; Tidball-Strickler, 1975. These four areas and their goals include:

1. Providing Emotional Support to Parents.
    a) helping parents accept what it means to have a handicapped child.
    b) helping them reduce their anxieties caused by guilt and feelings of inadequacy in the family.
    c) helping them toward realistic expectations about their child.
    d) providing stimulating activities to increase parents' feelings of self-worth.
2. Exchanging Information.
    a) to provide parents with an understanding of the rationale, objectives, and activities of the program in which their child is enrolled.
    b) helping parents understand child growth and development and the impact of their child's handicap.
    c) helping parents understand child behavior in the home.
    d) maintaining consistency and reinforcement of training or educational concepts.
3. Providing Parent-Child Interaction.
    a) providing information to parents on topics which will improve their knowledge of intervention and interaction strategies.
    b) providing opportunities for parents to develop skills in child-rearing practices.
    c) providing opportunities for parents to develop skill in

fostering growth and development of the child.

4. Increasing Parent Participation
    a) involving parents in the ongoing activities of the program.
    b) giving parents an opportunity to express their needs and to develop programming around them.

Cansler, et. al. (1975) adds another area -

5. Facilitating the Use of Community Resources
    a) referral and coordination of educational, medical, financial services.
    b) increasing parents' knowledge of community resources.

STEPS IN ESTABLISHING THE PARENT PROGRAM

In order to accomplish the above intentions, it is necessary to follow the same process as in planning for the total program. An important first step is to hire staff who support working with families. If staff feel threatened by parents and are not committed to working closely with them, parent involvement efforts cannot be successful. It is wise for the administrator to assess attitudes towards parents before hiring prospective staff.

Consider staff responses to such questions as:

-Do you see the family as a focus of the program?

-How do you see the parents functioning with the training team?

-What alternatives do you feel must be made available to families?

-How do you react to families whose value systems are different than yours?

-How will you react to families who do not want to be involved at the level at which you would like to see them involved?

-How do you feel about parents gaining skills in teaching their child effectively? (adapted from Cansler, et. al., 1975).

Staff who are committed to parent involvement can work with parents to assess needs, to plan, implement, and evaluate the parent involvement component of the program. In Chapter 2, several goals, objectives and activities were suggested for the parent component. These, of course, may be altered or expanded to meet the needs of a specific target population, including:

- -varying socio-economic status
- -minority and ethnic population
- -urban population
- -rural population
- -"exceptional" parents (e.g. mentally retarded, deaf)
- -single parents
- -working mothers
- -working fathers
- -very young mothers

Consideration of the nature and needs of the parents being served is important to ensure the development of appropriate objectives and viable activities. The needs assessment should be ongoing, with new information being compiled with every new family, and re-evaluated with changes in situations or circumstances.

MEETING THE NEEDS OF FAMILIES

A family's needs come to the attention of educators as a result of the needs of the handicapped child. The child is referred to the school for further assessment, an evaluation is completed, and the child's needs are identified. (See Chapter 5). In the process of doing this evaluation, staff must interview parents and obtain information about the child's developmental history, family situation, and parental concerns. From these interviews staff may obtain some idea as to the family's needs, and, in fact, some provisions for services to families may be designated in the staffing.

After the child has been staffed it is important for the staff involved with the child to work closely with the family in the implementation of the child's program. It is important that further family assessment be done to clarify family strengths and needs. Klein, et. al. (1978) suggests that family needs be explored in an informal discussion rather than a question and answer format. The parent/family worker or designated staff member should make an effort to visit with both parents in their home environment. Identification of the professional's role and establishment of rapport is an important beginning. General issues about which parents may have concerns can then be discussed including:

1) Parenting issues:
    - problem behaviors of the children - discipline
    - understanding their handicapped child's individual developmental stages
    - stressful times for the family
    - concerns about families teaching roles
    - provisions for play activities
    - parental expectations of the child's performance
2) Family maintainence:
    - special survival needs (food, clothing)
    - health, safety concerns
    - distribution of roles and responsibilities
    - satisfaction with roles and responsibilities
3) Communications:
    - support systems within the family
    - how are stress and conflicts handled?
    - how are special needs of family members met?
4) Leisure time:
    - fun things the family does together
    - special interests or hobbies of family members
    - relief from parenting, time for parents to be alone
    - social outlets outside of the family (Klein, et. al., 1978, p. 37).

Barnard (1976) and Bradley and Caldwell (1977) also recommend observations of the home environment to determine the level of home stimulation.

This informal discussion will allow staff to identify areas of parental concern, patterns of family interaction and value systems. It is also important to look at how the family is already dealing with their problems, rather than automatically imposing an external process on the family. The strengths of the family can be noted and pointed out. A more formal questionnaire or written needs assessment may also be done after the informal discussion. A comprehensive approach to families needs should be taken. Even if the agency cannot meet all identified needs, other resources can be coordinated to assist the family.

After gathering all the information, the staff member should summarize the family's concerns and list the needs and strengths that the family has to bring to bear on the existing problems. The home visitor can help the family prioritize the needs and facilitate the development of two or three realistic long-term (annual) goals. Klein et. al. (1978) suggests that family must decide on its own goals and objectives to fit its personal value system, individual needs and vision of optimum family functioning" (p. 35).

Tne home visitor can then take these goals back to the team to determine specific objectives which will aid families in moving toward their desired goals. Alternative activities for each objective can then be listed. For example, a family may identify as one of its priorities the improvement of their skills in working with their handicapped child. The team might list the following short-term objectives for the family under this goal:

1. To teach the parents five techniques for encouraging Mary's language.
2. To teach the siblings six toys they can play with together with Mary.
3. To reduce the time it takes mother to feed Mary.

Alternative means for accomplishing objective number 1 might be:

-to have family members observe the speech and language therapist working with Mary;

-to have the home visitor make weekly visits to observe the family working with Mary;

-to have family members use video-tapes of language techniques;

-to provide the family with materials, books and articles of language techniques appropriate for Mary.

Similar alternatives are selected or developed for each of the objectives which have been written. As the program develops the team will be able to add to the growing list of objectives and alternative activities which serve as a curriculum guide for parent involvement. Goals, objectives and activities should be organized into logical sections and serve as a guide and resource for future work with families.

After listing all the possible alternatives, the family should be given the opportunity to select those activities which are most feasible for them. A schedule for implementation can be determined and methods for evaluation of progress outlined. Coordination with other agencies to provide other resources to meet family needs should also be undertaken.

The level and type of involvement for each family will vary. Consideration should be given to the emotional readiness of parents to participate. A gradual involvement is often appropriate and necessary. Programs often make the mistake of offering only one or two parent involvement options, for example, parent groups and home visits. The result is often limited involvement or high parent attrition because the program is not individualized to meet their needs.

DELIVERY OF SERVICES TO PARENTS

The following section will analyze the types of services which are often delivered to parents and a variety of alternative methods for accomplishing the previously stated goals. Guidelines will be discussed for:

1. Sharing information with parents
   - in staffings
   - in conferences
2. Counseling with parents
   - individually
   - in parent groups
3. Working with parents at home
   - as teacher
   - as consultant and resource
4. Working with parents in the classroom
   - as observer
   - as aide
   - as teacher
5. Parent education
   - in classes, workshops
   - newsletters
   - resource room for parents
   - video tapes
   - parents inservicing parents
   - other alternatives

SHARING INFORMATION WITH PARENTS

Staffings. The staffing process has been discussed in Chapter 5, however, the parent's involvement in the staffing is worthy of further discussion. This is for many parents the first time they are hearing information on their child's difficulties. Quite naturally it is a highly stressful time. Staff need to have an idea before the staffing of what parents have previously been told. Knowledge of the parents feelings about what they already know is also important. The following considerations have been found to be important to parents:

1. Involve parents prior to the staffing in order to reduce the impact of the information. If parents are given an opportunity to absorb, integrate, and feel prior to the staffing, they can listen more carefully at the staffing. They also can ask questions which they might

not have had time to formulate otherwise.

2. Utilize a case manager or person who will act as the support person and advocate for the parents if they feel uncomfortable in asking questions. This person should also meet with the parents prior to the staffing to explain the staffing process - the testing which was done, how to interpret profiles, and how individual instructional objectives are developed.
3. It is helpful for parents to be able to bring another parent along for support.
4. Relate assessment data to behaviors which parents can observe at home.
5. Relate assessment data to the child's needs.
6. Use language and terminology that parents can understand.
7. Allow parents to express their feelings without being judgmental. As noted previously, it is natural for parents to deny the handicap, show anger at professionals, or grieve. Professionals need to be supportive of parents and listen without becoming defensive.
8. Keep parents involved and contributing information throughout the staffing.
9. Provide follow up to parents soon after the staffing. Parents may benefit from being contacted by other parents of similarily handicapped children. They may benefit from counseling, or they may want additional information. (Amon, 1978).

CONFERENCES

Parent conferences with school age children are usually scheduled once or twice a year to examine the child's progress. With young handicapped children these conferences should be quite frequent. In many programs these conferences are informal and much information is exchanged in home visits or when the parent drops the child off or picks the child up after class. When scheduling conferences with parents there are several points to consider:

1. Establish objectives or what you want to accomplish before the meeting.
2. Report with concrete or graphic illustration:
    - -skills the child has accomplished
    - -skills on which the child is presently working
3. Be positive. Get feedback from parents on how they perceive the child's progress at home.
4. Get the parents input on what skills they feel are important to work on in the future.
5. Ask parents for an evaluation of the child's program and their satisfaction with progress.
6. Provide follow-up activities for the child at home. Give demonstrations of specific techniques.
7. Discuss other needs the family may have. Be flexible, if parents have important concerns staff should be able to adapt their original agenda.
8. Before ending the conference have the parents summarize the information presented as they have understood it. This may avoid misunderstandings and misinterpretation of information.
9. Keep records of parent conferences including:
    - -the objectives of the meeting
    - -information covered
    - -parental concerns
    - -arrangement for follow-up

COUNSELING WITH PARENTS, INDIVIDUAL COUNSELING

"Counseling is a helping relationship between a knowledgeable professional and parents of an exceptional child, working toward a better understanding of their unique concerns, problems or feelings. It is a learning process focusing upon the stimulation and encouragement of personal growth by which parents are assisted in acquiring, developing, and utilizing the skills and attitudes necessary for satisfactory resolution to their problem or concern. Parents are helped toward becoming fully functioning individuals who are assets to their children and value harmonious living as members of a well-adjusted family unit." (Stewart, 1978, p. 21-22).

Although there are many definitions of counseling, Stewart's definition points out the importance of

-understanding
-learning, and
-acquiring skills,

and seems particularly relevant to staff working with parents of handicapped children. Although the social worker or parent/family worker is often given the responsibility of counseling with troubled families, all staff members need to have counseling skills to enable them to deal with families' concerns as they arise. Persons who have daily contact with the parents are most likely to develop a trust relationship which is so essential to effective communication. The development of good communication skills is an important goal which should be addressed in the staff development component of the program (see Chapter 8). Basic counseling approaches which should be addressed include:

-non-directive
-directive
-problem-solving

Non-directive counseling (Benjamin, 1974; Brammer, 1973; and Rogers, 1951) is used for gaining greater understanding of a problem. Counseling techniques which are inherent in the nondirective approach are important skills for all staff to be able to utilize. The ability to listen to parents' concerns is paramount. The intent of non-directive counseling is for parents to come to understand their feelings and arrive at solutions to their problems on their own. The role of the staff is to provide support and aid parents in clarifying their own strengths and abilities. Demos and Grant (1973) characterize nondirective counseling as:

a) Relying on data offered by the parents;
b) Being concerned about emotions (reacting to the emotional content);
c) Being concerned with human relations;
d) Emphasizing the personal social area;
e) Utilizing active listening and interviewing;

Several skills which are important in nondirective counseling include:

1. Allowing parents to discuss topics they are concerned about, rather than leading the conversation.
2. Using open-ended questions. This encourages parents to decide what information is important.
3. Using paraphrases or rephrasing statements made by parents. Paraphrasing lets the parents know they are being heard. It also lets them hear how what they are saying is being understood. This gives them an opportunity to corrent misperceptions.
4. Using reflection of feelings. Stating how you think the parent is feeling at a particular moment in time is important. Often this helps parents to focus on and explore their feelings. The reflection of feelings allows bottled-up emotions to be freely expressed without fear of judgment.
5. Clarifying or asking for more information allows the listener to check perceptions.
6. Using indirect leads include nodding of the head, saying "mm-hmm", and allowing silence. Silence gives the parents time to think and lets them know you want to hear more.
7. Interpreting information which is being stated. This may allow parents to pinpoint aspects of thought or feeling that was not at a conscious level.

8. Confronting parents with information that they may not want to hear.
9. Summarizing the feelings, the content or the process which the counselor feels are important. Summarizing helps the parents to hear the major important points which have been stated.
10. Supporting and reassuring by letting parents know that their thoughts and feelings are important.

The skills involved in nondirective counseling are useful at times when the staff want to get a better understanding of the feelings that are associated with a particular situation. Use of these techniques is valuable at the beginning of any session with parents, as it helps establish a sense of trust and mutuality of understanding. These techniques are also important to weave into any session when a better understanding is desired.

BEHAVIORAL COUNSELING

Behavioral counseling (Bergan, 1977; Patterson, 1975) is useful for crisis intervention and positive action. When changes are needed quickly, behavioral counseling can be effective. Demos and Grant (1973) differentiate behavioral from nondirective as:

1. Reliant on data gathered by the counselor
2. Concerned with intellect (reacting to intellectual content)
3. Predominantly a specific approach
4. Primarily related to educational and vocational areas
5. Emphasizing a problem of the client.

Behavioral counseling is much more structured, with the counselor guiding the counseling session. It is a step-by-step process to which the parents contribute, but the final course of action is planned by the counselor.

1. Initial analysis of the problem situation. Determination is made of which behaviors are problematic because they occur with excess frequency, intensity or duration, or are problematic because they do not occur enough. Also determination is made of which behaviors are done well.

2. Clarification of the problem situation. The counselor explores with the

parents the situations in which the behaviors occur, the consequences of the behaviors and the probable effects of changing the behaviors.

3. Motivational analysis. The counselor explores with the parents what events are rewarding and punishing to the child and their effects in different situations.

4. Developmental analysis. The counselor explores any physiological limitations, earlier behavioral problems, any recent changes in the child's environment.

5. Analysis of self-control. Determination is made of behaviors the child can control and in what situations.

6. Analysis of social relationships. The counselor determines what social relationships the child has and how behavior varies within these relationships.

7. Analysis of the socio-cultural-physical environment. Exploration is made of the norms limitations, and expectations of the child.

8. Behavioral objectives are specified. The counselor and parents pinpoint a behavior to change.

9. Plan is developed. Antecedents and consequences are selected. Specific procedures for implementation are outlined, including reinforcement, schedule of reinforcement, timeline, and record keeping.

10. Evaluation of change. The counselor follows the progress and works with the parents to modify the program as necessary.

11. Plan for maintenance is developed. A schedule of reinforcement is planned to maintain the desired behaviors.

Behavioral counseling is most frequently used to modify problem behaviors of children. However, it can also be used to change parents' counter-productive behaviors.

PROBLEM-SOLVING COUNSELING

Problem-solving counseling (Carkhuff, 1969; Gordon, 1970) is a combination of nondirective counseling skills and behavioral counseling skills with some added components. The counselor uses nondirective skills to define and explore the problem. Behavioral skills (closed questions and directed questioning) may also be used. The important difference is the involvement of the parents in identification and evaluation of alternative solutions.

Carkhuff (1969) outlines a seven stage process for problem-solving:

1. Define and describe the problem situation. This includes exploration of the parents' feelings about the situation.

2. Definition and description of the direction (s) and/or goals dictated by the problem areas. This allows the parents and the counselor to work together to determine the types of changes they would like to see.

3. Describing existing conditions related to the problem and hindrances to accomplishment of goals.

4. Discussing all the possible alternatives to solving the problem. Judgments should be withheld at this time of brainstorming.

5. A consideration of the advantages and disadvantages of the alternative courses of action. The parents are actively involved in determining the course of action which is most feasible for them.

6. Development of physical, emotional-interpersonal, and intellectual means for achieving the selected alternative. Parents need to determine the course of action and support systems which will allow them to follow through on the plan.

7. The development of progressive gradations of the program including evaluating the outcome and making future plans.

Problem-solving counseling can be used to deal with a variety of family related problems. It is also an effective method to teach parents, in order to help them to cope with new problems as they arise. Home visitors find the process particularly effective for encouraging parents to think of new alternatives for working on a child's objectives. As parents gain more

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confidence in their abilities to solve problems, the counselor can become more of a resource and support system. The goal of each of these counseling approaches is to help parents become more confident and self-sufficient. Counselors should build on the families strengths. Different approaches may be needed for different problems. It is also important that counselors know their own strengths and limitations and know when to refer families for more intense professional counseling.

PARENT GROUPS

There are many types of parent groups, but the most common is a support group which derives the content of its discussions from the interests and concerns of the parents. By sharing their knowledge and experiences, parents help each other to "examine, clarify and understand a specific aspect of their life situation-their role as parents - and use the dynamics of group learning to help them become more capable and self-assured" (Brown, 1978 p.2).

Parents gain a sense of mutuality and recognition from the group. In parent groups the supportive environment encourages discussion of reactions and feelings. By seeing themselves mirrored in the acts and statements of others, parents can pin-point their concerns and develop a deeper awareness and understanding of themselves and their relationships to other family members. They may gain knowledge and information in a non-threatening, non-authoritative setting. They may acquire methods for approaching problems, exploring alternatives and making decisions. Parents can also discuss and evaluate difficult upcoming choices with others who may have faced similar situations. In addition, the friendships and opportunities for socialization which arise provide important opportunities to release parents from the isolation which they may feel.

The success of parent groups depends in large measure on the skills of the staff member who acts as the group facilitator. This person needs good individual counseling skills as well as skills in conducting group sessions.

The group needs to identify specific concerns or problems the parents are having. The group leader can help focus the group by asking open-ended questions (not theoretical but about real life situations) and then narrowing down the topic to one which is of mutual concern or one which is presenting a major difficulty requiring immediate resolution. The facilitator needs to be able to create a relaxed environment and set parents at ease. Respect should be shown for the parents' individual values and ideas.

Barnard and Erickson (1976) say the group leader also:

1. Keeps the purpose of the meeting clear, collects the agenda, helps in decision making by checking with all group members to assure that the topic under consideration is the one most preferred by the total group.
2. Teaches and models clear communication.
3. Gets opinions of both positive and negative experiences.
4. Expresses feelings when painful experiences are evident.
5. Supports individuals in their endeavor to express themselves.
6. Helps assess problem-solving abilities of the group as a whole.
7. Gives verbal feedback regarding approaches.
8. Acts as a mirror for progress by always offering to summarize major points or in-depth topics covered in each session (p. 57).

The group facilitator must be able to keep the meeting within the designated time frame, attend to the needs of all group members, control the process and level of interaction, and confront when necessary. Traffic directing is also an important task - blocking gossip, "super-Mothering", and invasion of privacy, are behaviors that should be controlled. The group leader must be a model of good communication and a catalyst to interaction. He/she helps the group to find their own answers, but adds information, summarizes and underlines healthy attitudes and strengths.

It should be recognized that not all parents need or want to be members of a parent group. Participation may be needed only to help a parent through a particular crisis or difficult time. Amon (1978) notes that "parent groups are often non-productive and often poorly attended because parents are at different stages in coping with the crisis of having a handicapped child (denial, depression, anger, guilt, bargaining, or acceptance). As new parents enter a group at one level, they cause parents at other levels to leave. Or, in many cases, the group simply doesn't meet their needs." Amon also states that husbands and wives move through crisis at different levels, and therefore have different needs. Also, single parents often feel uncomfortable in a group of couples. In planning for parent groups, staff need to be aware of these individual differences and plan a variety of types of individual and group opportunities.

WORKING WITH PARENTS AT HOME

The home is the child's natural setting, and parents are the child's primary teachers. Therefore, the home is a natural learning environment. Home visitors play different roles depending on the needs of the family and the philosophy and goals of the program. The home visitor may

1) work directly with the child while parents watch.
2) work directly with parents, who then work with the child.
3) work with child and parent, by modeling techniques for the parent, who then tries the techniques.
4) talk to the parent and give suggestions about what to do.
5) leave printed materials for the parents to read.
6) problem-solve with the parent about child, family and personal problems.
7) leaves toys and materials for the family to use.

The primary purpose of home visits is to increase the family's ability to cope with and interact with their handicapped child. As a result of all of the previously discussed reactions to the birth of a handicapped child and also as a consequence of the child's lower level of interaction, attachment bonds may not be as strong as between a normal child and parents. Freiberg, Smith, and Adelson, 1969; and Klaus and Kennel, 1976 have noted that promotion of love bonds between parent and child are paramount to educational success. The continual promotion of positive pleasurable interaction between parent and child is as important as the development of motor and cognitive skills. The home visitor needs to work with the child to facilitate the acquisition of behaviors which will allow the child to maximally interact with the family. As the child increases attention to the environment; as he/she learns to manipulate objects and events in the environment; as gestures, sounds and words allow the child to communicate with people in the environment, the more reinforcement parents receive and the greater the desire of the parents to interact with the child. The more positively the parents engage their child, the more opportunity the child has for continued growth. It is a positive cycle which can replace a negative cycle which is not reinforcing to either parents or child. Gordon (1979) in summarizing his research, discusses elements which need to be present in the home to optimize learning. He calls them the "five p's", the "four r's" and TLC. The five p's include:

1. provision of a learning environment - which has opportunities for variety of stimulation and is organized to facilitate exploration.
2. predictability - a sense of order and system that children can come to understand.
3. ping-pong - Gordon describes this as a form of adult-child interaction where "I do something, you do something."
4. persistence - allowing the child total involvement in activities.
5. professor - which is a negative pattern consists of continual talking

on the part of the parent with no attention paid to the child's responses. The four r's are concerned with:

1. responsiveness - to the child's initiative and needs.
2. reasoning - encouraging problem - solving on the part of the child.
3. rationality - providing explanations for events.
4. reading - the provision of reading materials, even to infants.

and the last - TLC or tender loving care which means that all of the above must be provided in an atmosphere of warmth.

The home visitor works on helping families to develop such a learning environment. The home visitor must be trusted and respected by the family. Although this trust and respect often develops over time, it is important to spend time with the family just listening and establishing rapport. It is also important to make arrangements for both parents (in two-parent families) to be involved in some way. It is not always wise to have the mother be the person to transfer information to the father. This can set up a difficult situation in which the mother feels she has all the answers and tries to tell the father what to do. Obviously, this pattern may lead to difficulties between husband and wife. It is better to either come to the home when both parents are present or make some visits when the father can be there. Flexibility in scheduling is important!

Whether the child is in a home-based program or home and center combined, the emphasis on both family and child should be strong. Many center-based programs provide home visits only for the purpose of teaching parents how to follow through on skills learned at school. The emphasis in any home visit should be the child's functioning in the home environment and the interaction among the family members and the child.

One of the important tasks of the home visitor is to help parents develop good observation skills. This may be done by sharing observation check lists and criterion referenced assessment tools with parents. Through such observation the parent can:

-understand their child's different rates of growth in different developmental areas.

-understand the steps and usual sequences in acquiring skills

-develop realistic expectations.

-provide data that is a basis for recording progress.

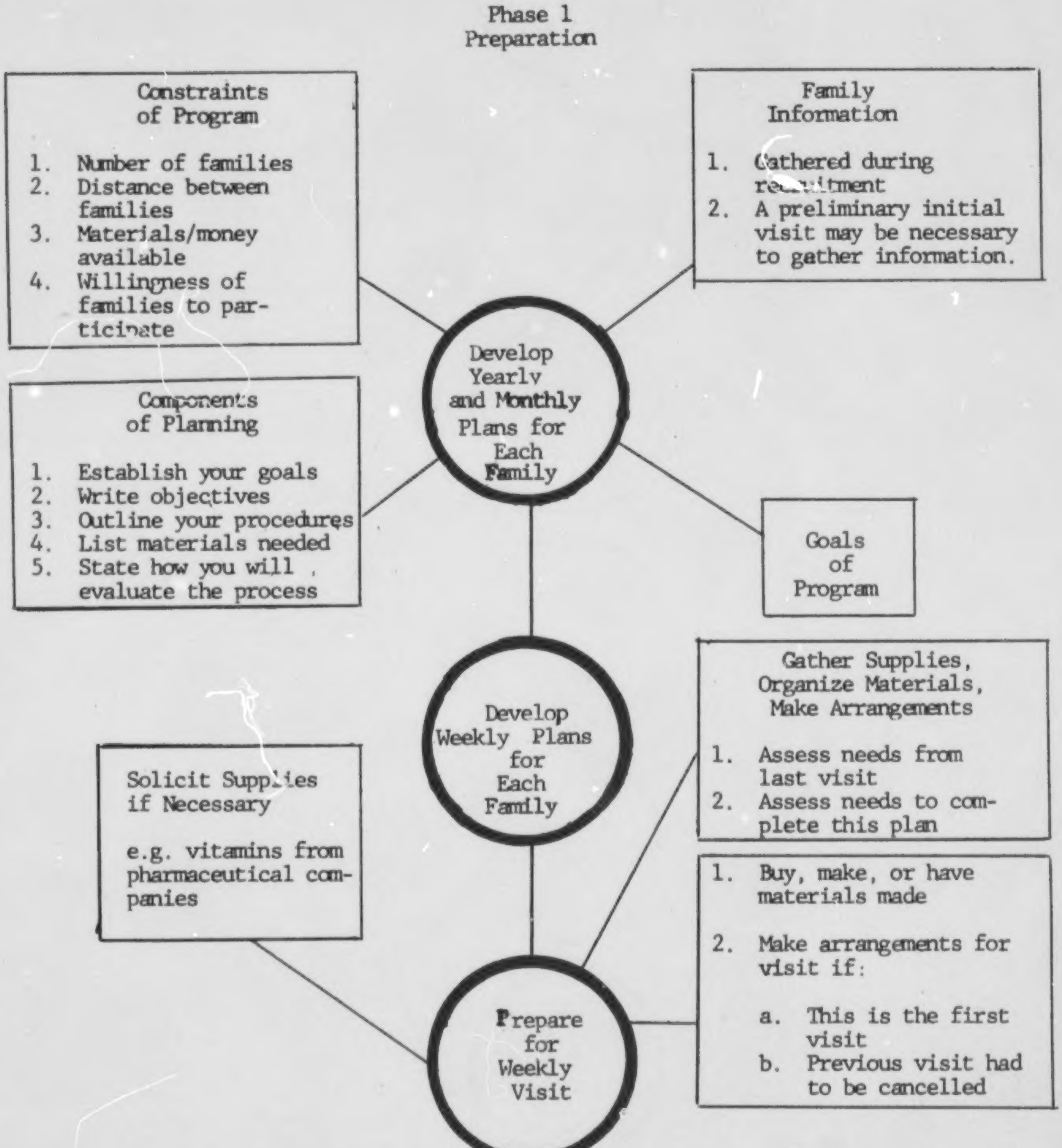
-be involved in coming up with suggestions appropriate for activities (Cansler, et. al. 1975).

Observation skills can also help parents in: a) pinpointing problem behaviors, b) establishing the frequency, duration and intensity, and c) determining the relationship between behaviors and the consequences they produce (Haring, 1976).

After helping parents to determine where and how the child is functioning, it is imperative that the home visitor demonstrate intervention strategies and work with the parents in developing alternatives for them to implement immediately within the home environment. A good place to begin is to focus on behaviors that will improve the interaction level between the parent and child. For example, if the child is difficult to feed, and every meal is a two hour frustrating struggle, then it is appropriate to begin working on feeding skills. The priorities that parents have at home may be different from those at school. Morrison (1979) has devised a model for the home visitation process, which is depicted in Figure 1, pages 277-279

FIGURE 1.

THE HOME VISITATION PROCESS


Phase 1
Preparation
Constraints of Program
1. Number of families
2. Distance between families
3. Materials/money available
4. Willingness of families to participate
Family Information
1. Gathered during recruitment
2. A preliminary initial visit may be necessary to gather information.
Develop Yearly and Monthly Plans for Each Family
Components of Planning
1. Establish your goals
2. Write objectives
3. Outline your procedures
4. List materials needed
5. State how you will evaluate the process
Goals of Program
Develop Weekly Plans for Each Family
Gather Supplies, Organize Materials, Make Arrangements
1. Assess needs from last visit
2. Assess needs to complete this plan
Solicit Supplies if Necessary
e.g. vitamins from pharmaceutical companies
1. Buy, make, or have materials made
2. Make arrangements for visit if:
a. This is the first visit
b. Previous visit had to be cancelled
Prepare for Weekly Visit

*From Morrison, G.S. Parent involvement in the home, school and community. Columbus, OH: 1978 Pgs. 85-87

Figure 1 - Phase II
Conducting the Visit

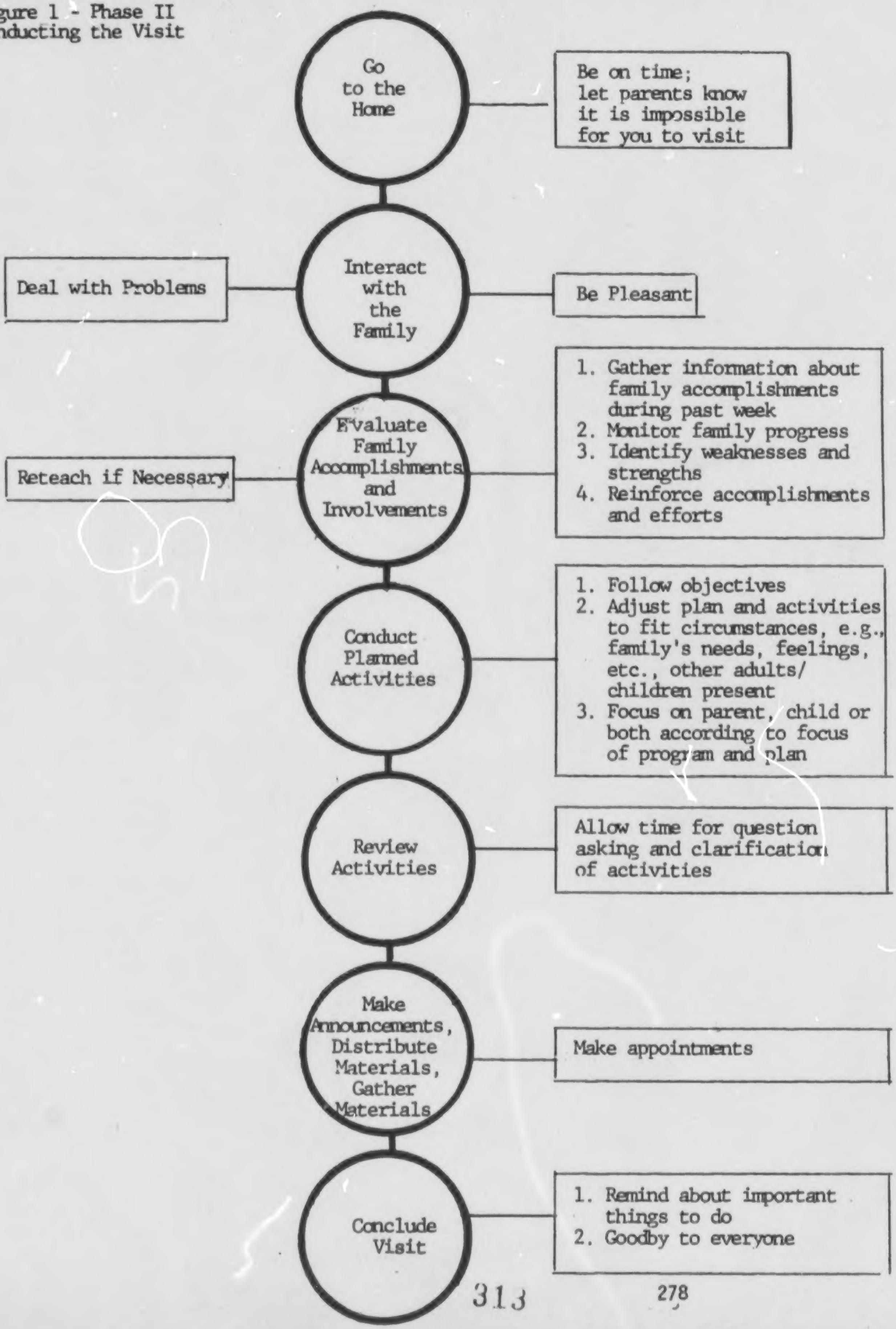
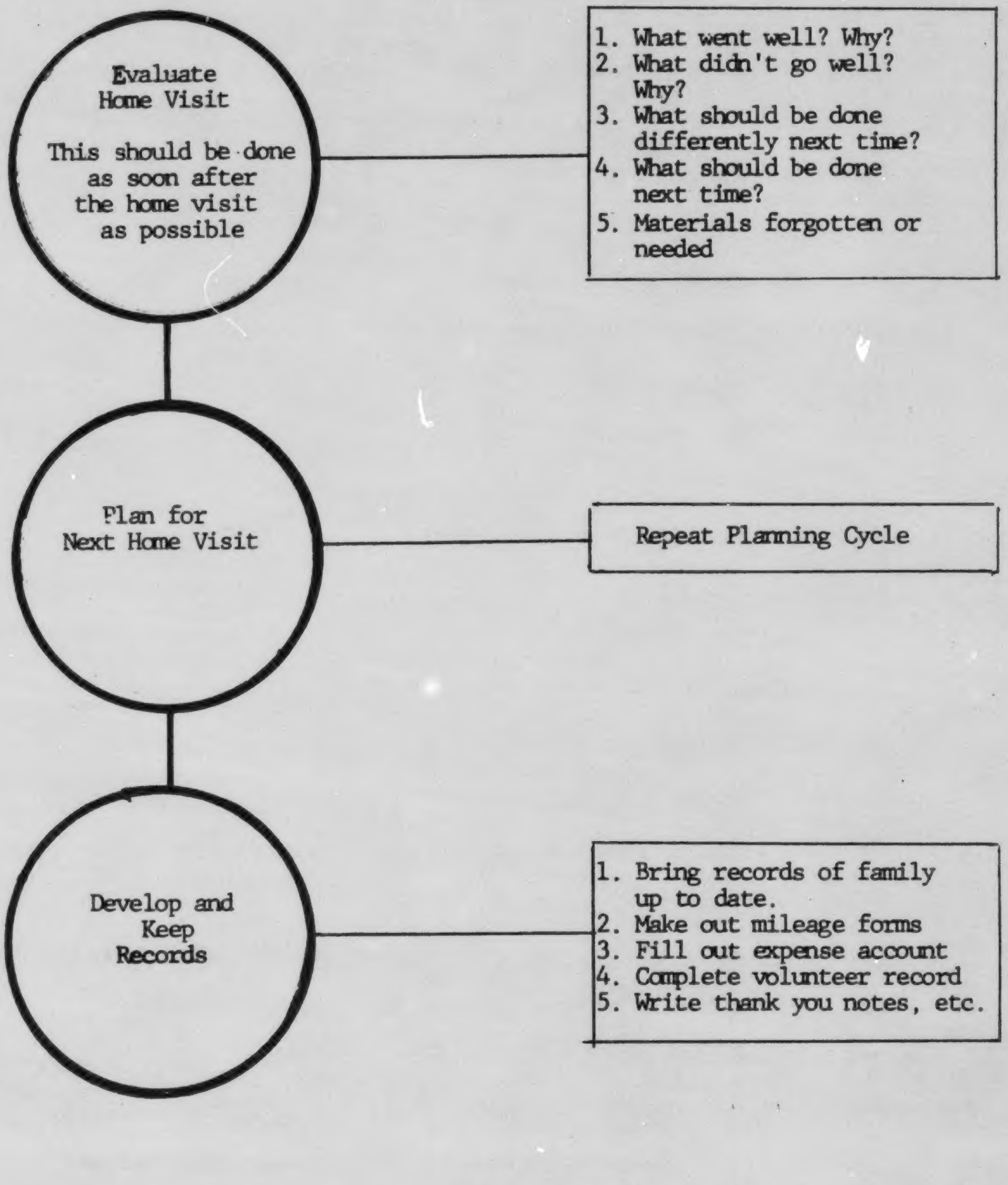

Go to the Home
Be on time; let parents know it is impossible for you to visit
Interact with the Family
Deal with Problems
Be Pleasant
Evaluate Family Accomplishments and Involvements
Reteach if Necessary
1. Gather information about family accomplishments during past week
2. Monitor family progress
3. Identify weaknesses and strengths
4. Reinforce accomplishments and efforts
Conduct Planned Activities
1. Follow objectives
2. Adjust plan and activities to fit circumstances, e.g., family's needs, feelings, etc., other adults/ children present
3. Focus on parent, child or both according to focus of program and plan
Review Activities
Allow time for question asking and clarification of activities
Make Announcements, Distribute Materials, Gather Materials
Make appointments
Conclude Visit
1. Remind about important things to do
2. Goodby to everyone

Figure I

Phase III

Evaluation, Review,
Planning, Record Keeping


Evaluate
Home Visit
This should be done
as soon after
the home visit
as possible
Plan for
Next Home Visit
Develop and
Keep
Records

1. What went well? Why?
2. What didn't go well? Why?
3. What should be done differently next time?
4. What should be done next time?
5. Materials forgotten or needed

Repeat Planning Cycle

1. Bring records of family up to date.
2. Make out mileage forms
3. Fill out expense account
4. Complete volunteer record
5. Write thank you notes, etc.

GUIDELINES FOR HOME VISITS

1. Prepare for each visit.
2. Have written objectives and activities for each home visit. Have a copy to leave with the parents.
3. Involve the parent in planning. Add objectives and activities to the plan that are developed jointly by the parents and the home visitor.
4. Demonstrate activities and procedures for the parent.
5. Have the parent try activities.
6. Provide feedback and reinforce the parents' successes.
7. Make sure the parents experience success. Structure visits so parents are watching for positive signs of growth.
8. Show parents how to keep a simple recording system to monitor progress.
9. Individualize for families.
10. Involve siblings in working and playing with the child.
11. Use counseling skills as necessary.
12. Know community resources and know when to refer parents and/or the child to other services.
13. Have frequent team meetings to discuss home programs.
14. Be careful that parents do not become dependent on the "specialist".
15. Do not pressure parents to have the child accomplish certain skills, as this may result in pressure on the child and damage the parent-child relationship.
16. Having a visitor in the home on a regular basis is often a strain. Be willing to "ease-up" when parents need space.

The home visitor also needs to focus on play behaviors. Help the parents to engage in pleasurable interactions with their child. Often handicapped children come to be seen as "therapy objects" and parental interactions revolve around "working" with the child (Linder, 1980). Parents need help in learning how to play with their child. Facilitation of development can be done through pleasurable interactions with the child.

WORKING WITH THE PARENTS IN THE CLASSROOM

Observations. As in the home visit, it is important to teach parents how to observe and assess their child's growth and development. Classroom observations, with guidance from the staff can help parents to see:

1) the strengths of their child;
2) how the team contributes to the child's growth;
3) how the team handles specific behaviors;
4) how the child can benefit from home activities;

(Tidball-Strickler, p. 34);

Staff should develop guidelines for classroom observation with the input from parents in the program. It is also important for the staff to meet with the parent prior to the observation to discuss with the parent the objectives of the program and activities that are done to work on individual programs. The teacher needs to explain teaching methods and behavior management techniques which are used. After the observation staff need to meet again with parents to discuss their observations and their child's strengths and progress. They need to be willing to answer parents' questions, but keep information on other children confidential. This is also an appropriate time to focus on the need for consistency between home and school. The staff and parents may problem-solve appropriate activities that can be done at home. With some parents a checklist or an open-ended form with spaces for notations under specific categories can be devised. The parent can then observe with a purpose in mind.

PARENTS AS AIDES OR VOLUNTEERS

Parents who act as aides in the classroom can benefit from the above mentioned activities as well as having the advantage of learning over an extended period of time. There are many roles that parents can assume and whenever possible they should be given the opportunity to choose the activities they prefer. Some parents feel uncomfortable working directly with the children, while others prefer to work with other people's children rather than their own. Parents can work on a one-to-one basis with a child or with small groups. They may be responsible for supervising specific activities or they may prefer to help out in non-teaching roles. In this case, parents can help by creating new materials, performing clerical duties such as record keeping, or maintaining classroom materials. Whatever tasks are assigned should be meaningful and selected by parents as tasks they would enjoy.

Regardless of the role that parents play, two important points should be noted:

1. Staff attitudes toward parents in the classroom must be positive to work effectively.
2. Parents should be trained for the functions they perform.

The first, needs to be addressed when staff are hired and during inservice. To accomplish the second, it is necessary to provide parent inservices (this can be done by other experienced parents) or include parents in staff inservices.

Morrison (1979) discusses the benefits of having parents involved in the classroom:

-Parents can make the program more efficient and effective.

-Children will benefit from interaction with other adults.

-Parents have a variety of talents they can share with children and staff.

-Working in the classroom can enhance the parent's self-concept.

-Parent involvement in the classroom can enhance interpersonal relationships among family members by giving them topics to discuss.

-Parent involvement can increase the parent's understanding of the educational process.

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-working with parents in the classroom can increase the staff's understanding of the parent's concerns (p. 152).

If carefully planned, having parents (and even siblings) in the classroom can be a worthwhile experience for all involved.

Parents as teachers. Parents who have been involved for some time or who are in home and center-based programs may become more autonomous in working with children. They may be able to help with evaluations, planning, and teaching of the children. After observing staff working with the children, parents can perform all of the activities demonstrated by the staff. While the parents are working with the children staff can give them feedback, reinforcement and ideas for working with the child at home. Parents can also be useful as teachers of other parents and volunteers who come to the program. Given meaningful involvement, parents can contribute greatly to the effectiveness of the program and to the growth of their child.

PARENT EDUCATION

Parent education involves providing parents with information that will increase their knowledge and skills in parenting. For parents of normal children parent education classes have become very popular. For parents of handicapped children who have additional parenting responsibilities, parent education is very important. There are many different forms of parent education from informal discussion in meetings with parents to formal courses. The previously discussed work with parents in home visits or classroom visits can contain much parenting information. However, it is often desirable to provide a more structured approach to the content that parents request or need. At the beginning of the year an assessment of parent's needs should be completed, usually as part of an initial interview. In developing the needs assessment, staff should attempt to be as specific as possible in addressing topical areas. For example, a commonly used form lists topical areas with blanks after them to be checked. See Figure 2.

Figure 2 NEEDS ASSESSMENT - SAMPLE ITEMS

PLEASE CHECK THOSE ITEMS WHICH YOU ARE INTERESTED IN LEARNING ABOUT

Behavior management ____
Child development ____
Handicapping conditions ____

In examining the items, one can see they are too vague. There are many different types of behavior management approaches, and the term itself may be confusing. The term "child development" can include just about anything. Another problem with this approach is that it does not give the staff any idea what priorities are assigned to the items if more than one is checked. Also, the staff has no idea of how parents would like to receive the information or at what level.

Figure 3 is an example of another needs assessment form which takes into consideration these problems. (See Figure 3, next page)

Once the staff have done a needs assessment of parents' interests they may also want to assess what staff feel are important parent education topics. After the information has been collected, planning can take place. Parents should be represented on the parent education planning team to develop the format and specific activities.

Love (1979) states that parent education classes should have:

-well defined, measurable objectives
-specific motivational strategies
-curriculum relevant to the diversity of parents - culturally, ethnically and economically
-techniques for ensuring continuity
-methods for ongoing documentation and assessment

FIGURE 3. SAMPLE ITEMS FROM NEEDS ASSESSMENTS FOR PARENT EDUCATION

TOPIC	PRIORITY (put no. 1 by your first choice, no. 2 by your second choice, etc.)
How can I help improve my child's language?	____
What can I do when my child misbehaves?	____
What kinds of toys are appropriate for my child?	____
Etc. (Other topics as appropriate)	

Other:

Preferred Format

Films, tapes ____
Group Discussion ____
Panel Discussion ____
Workshop ____
Role Play ____
Lecture ____
Demonstration ____

	YES	NO
I would be willing to help plan the meeting	____	____
I would like to carpool to the meeting	____	____
It would help if child care were provided	____	____

Time Preference ____ Morning ____ Afternoon ____ Evening

Preferred Day M____ T____ W____ TH____ F____

I would also be interested in informal meetings with other parents in the program.

	YES	NO
parent group discussions	____	____
potluck	____	____
picnics	____	____
field days	____	____
Monday night football	____	____
field trips	____	____
learning a craft	____	____
other	____	____

Comments:

-provisions for evaluation - both formal and informal (p 24).

The range of topics that parents may desire is infinite. However, there are some suggested topics for prenatal, infancy and preschool areas that can be suggested. Although prenatal topics may seem outdated, keep in mind that parents of young handicapped children often have additional children, and one of their natural concerns is about having another handicapped child. Programs can play a very significant preventative role by providing parent education on prenatal topics. Lane (1975) offers the following list of topics for consideration.

AFTER CONCEPTION

-the psychological, physiological, and sociological changes of pregnancy and parenthood including real life experiences with children in their homes

-prenatal health, genetics, nutrition, the ramifications of diet and medication

-the intrauterine development of the fetus

-potential problems to be aware of and what to do

-labor and delivery - different methods of childbirth, the hospital, what happens

-selection of a good obstetrician and pediatrician; medical decisions which may arise

INFANT CARE

-infant care techniques: bathing, feeding, sleeping, playing, illnesses, developmental patterns of growth, safety

-child development fundamentals: physical, perceptual, cognitive, emotional, behavioral

- infant play and learning - how to stimulate movement and language
- nutritional needs of infants
- emotional needs for nurturance - creating early trust in environment, feelings of love, and self-esteem
- disciplining toddlers - behavior management and socialization techniques
- community resources - where to go for help

PRESCHOOL YEARS

- behavioral patterns
- their needs and developmental tasks
- physical, motor, (fine & gross), cognitive and language, psychological and social development as manifested in behavior
- suggestions for growth enhancement
- play activities
- appropriate toys and books
- family dynamics
- handling crisis situations
- discipline and behavior management
- community resources
- peer relationships
- acceptance of children's feelings and attitudes (pg. 18-20)

Other topics which parents of handicapped children have requested include:

- sensorimotor development
- behavior modification
- selection of appropriate toys and games
- perceptual development
- developing a positive self-concept
- handicapping conditions and medical terminology
- understanding medications

-legislation for the handicapped

-how to plan for the child if something happens to the parents

Depending on the topic chosen and the level of information desired, the format will vary. Options which may be tried include:

-group discussion of ideas

-panel discussion

-small group discussions

-symposium

-workshop

-reaction sheets

-role playing

-debate

-brainstorming

-field trips or observations

-audio visual aids

-lecture on information

-parent inservices

-resource room

-film series or books with discussion

-series of classes

-reading groups

-video tapes and discussion

-newsletters

In order to ensure maximum participation provisions should be made to take care of basic needs (refreshments), transportation and child care. Parents will not continue to attend if programs do not meet their needs by providing information which is immediately relevant. This, of course, means that a variety of options need to be available at any one time.

GUIDELINES FOR PARENT EDUCATION

1. Work with school administrators, staff, resource people, and parents to plan the parent education program.
2. Needs assessments should be done by interview if possible.
3. Work with community agencies to help meet the total needs of parents.
4. Provide opportunities for informal communication along with the parent education sessions.

5. Hold meetings on convenient days and times with the parents preferred format.
6. Design and distribute attractive flyers or announcements.
7. Use parents to make personal contacts to parents to remind them of upcoming sessions.
8. Have parents organize a car pool.
9. Arrange for child care.
10. Use the news media to help publicize activities.
11. Do evaluations of all sessions to provide for program improvement.
12. Provide follow-up to parents who desire it.

RESOURCE CENTER

In addition to formal meetings parent education can be accomplished through many informal means. For parents who enjoy reading materials, books, pamphlets, articles, journals may be made available on topics of interest.

A resource room for parents can become an active "parent room". A comfortable room with a couch, overstuffed chairs, and a coffee pot can provide a "place" for parents that is all their own. After they drop off their child, after a meeting, or while waiting for a class session to end, parents can enjoy an informal opportunity to talk to other parents or just sit and relax. Books and journals such as Exceptional Parent should be available for parents to peruse or check out. Toys, materials, and activities can also be available in this room. A parent room can also provide an informal, comfortable setting for discussions with a parent or group of parents. A resource room can contain such materials as:

-books, games, records, pictures, manipulatives for use with children at home, including a card with directions for how to maximize play opportunities.

-materials on parenting, child development, nutrition, community agencies and organizations, etc.

- suggestions for use of household items in teaching children at home.
- materials for parents to make for use at home. Staff can conduct toy-making workshops while educating parents on developmental aspects of play and learning.
- a parent bulletin board with a calendar of events, community resource information, current legislation, pictures of children and parents, information on parenting issues.

NEWSLETTERS

Newsletters can be very effective in both increasing communication with parents and also providing parents with information on parenting and educational topics. Putting together a newsletter can take quite a bit of effort. Utilization of a "parent press corp" can greatly aid staff in putting together a quality newsletter. Cansler (1975) has suggested possible topics to be included in newsletters which go home to parents:

- reports of children's learning experiences, opportunities for parent and staff training, announcements of group meetings, and special activities.
- suggestions for helping children at home and printed instructions for making inexpensive toys or teaching materials.
- facts concerning community services and organizations for families, and discussions of local, state and national issues related to handicapped children.
- a "meet the staff" section to introduce parents to the persons working with their children.
- recognition and thanks for parents' contributions to the school program.
- descriptions of specific tasks that require the assistance of volunteer workers.

-descriptions of books and toys available in a lending library as a way of encouraging the use of such a service.

-a "Parent Exchange" section to help families locate others interested in exchanging services (child care or transportation) or goods (p.40).

PARENT HANDBOOK

Providing information on the program and details on school policies and procedures is also important. Information should be written clearly and simply. The philosophy and goals of the program should be explained. Examples of school forms should be included with explanations of the uses of information obtained. A delineation of services provided is also important. The following is suggested content to include in a handbook:

1. Philosophy of the Program
2. Admissions Procedures
3. Assessment and Placement Procedures
4. Health Care Policies
    - -medication
    - -illnesses
    - -communicable diseases
    - -accidents and emergencies
    - -absences
    - -clothing
5. Program
    - -classes and schedules
    - -home visits
    - -therapy services
    - -consultation
6. Parent Involvement Opportunities
    - -parent groups

-conferences
-parent education
-volunteering

7. Parents' Rights
8. Miscellaneous

PARENT ADVISORY COMMITTEES

Most grant funded early intervention projects mandate the inclusion of a parent advisory group to work with school administrators in planning and evaluating the program. The reason for this mandate is the recognition that parents are the "consumers" of early childhood programs, and, as such, deserve a voice in the decision making processes relating to services for their children. The success of these advisory committees is justification for early childhood programs to continue to involve parents at this level. Parent advisory committees can discuss their feelings and offer their opinions about policies, procedures and current issues which relate to program decisions. They can provide a needed perspective in developing program goals and objectives and in recommending curricular content. They can provide input into long-range planning and help maintain liaisons with other community agencies and organizations. Sub-committees can be formed to work on evaluation of program components. An active parent advisory group can give input and feedback on administrative decisions, as well as an advocacy base.

GENERAL CONSIDERATIONS FOR PARENT INVOLVEMENT

"Parents of handicapped children need assistance, support, acknowledgment, and objective feedback in their decision-making, problem solving, and planning for alternatives of care for their children" (Barnard and Erickson, 1976). Staff who keep in mind these needs will be able to plan and implement programs with families as the intervention focus. Buscaglia (1975) in his discussion of the basic rights of the family of a child with special needs, nicely summarizes our responsibilities to respect these rights:

- the right to sound medical knowledge regarding their child's physical or mental problem.
- the right to some form of continual re-evaluation of their child at definite periodic intervals and a thorough, lucid explanation of the results of the findings.
- the right to some helpful, relevant and specific information as to their role in meeting their child's special physical and emotional needs.
- the right to some knowledge of the educational opportunities for a child such as theirs and what will be required for later admission for additional formal schooling.
- the right to a knowledge of the community resources available for assistance in meeting the family needs, intellectual, emotional and financial.
- the right to knowledge of the rehabilitation services in the community and the resources available through them.
- the right to some hope, reassurance and human consideration as they meet the challenge of raising a child with special needs.
- the right to some help in seeing their child's potentials instead of forever concentrating upon his imperfections.
- the right to good reading material to help them acquire as much relevant information as possible.
- the right to some interaction with other parents who have children with disabilities.

-the right to actualize their personal rights as growing unique individuals, apart from their children (p. 109).

As professionals who care about handicapped children and their families, we have a responsibility to ensure that these rights are protected. The parent component of every early intervention program should provide mechanisms to guarantee that the needs of families will be addressed and their rights will be respected.

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EIGHT

STAFF DEVELOPMENT

Once staff are hired and the program becomes operational, how can the ECH coordinator ensure continued improvement and refinement of the program? How can the coordinator assist in the interchange of ideas and skills among the staff? What can be done to prevent staff burn-out? The answer to these questions may, in part, be the provision of a substantive and responsive staff development component.

In the Handbook for Development of Staff Training, developed by the Department of Special Education at the University of Texas at Austin, it is stated that

"Staff training is a planned sequence of experiences designed to foster a) continuing development of the understanding, skills, and knowledge of each staff member and b) cooperation, interaction, and integrated activity among the disciplines represented in a program. Thus staff training contributes to both individual and group development. Such development is necessary if the staff is to offer a high quality of services to preschool handicapped children and their families" (xi).

Staff development which is viewed as an integral part of the early childhood special education program, and is therefore carefully planned and implemented, can provide many worthwhile benefits.

1. The field of early childhood special education is relatively new. As such, there have not been sufficient pre-service training programs available to

meet the growing demand for qualified, capable personnel to work with young handicapped children. Programs have, by necessity, hired personnel trained to work with normal young children or older handicapped children. These persons are often unprepared to assume the multiple responsibilities working with young handicapped children (Karnes, 1975). Staff development can provide supplementary training to enable new personnel to acquire additional background and skills needed to adequately carry out their responsibilities.

2. The philosophical orientation of the training institutions from which staff have received their training may also vary. For example a behavioral approach, a psycholingustic approach, a sensorimotor integration approach, a cognitive developmental approach may have been emphasized. Methods which are stressed in the early childhood special education programs will need to be taught to new staff members who are unfamiliar with the theoretical and practical implications of these approaches. Often it is beneficial to have staff with differing backgrounds, as they can bring different perspectives to bear on very difficult problems relating to handicapped children and their families. This can expand the problem-solving capabilities of the staff. However, it is also important to have staff who understand each other, and can demonstrate consistent approaches. If various staff are utilizing different terminology and recommending inconsistent methodology, the results may mean confusion and frustration for the family and the child. Staff development can improve program consistency and reduce tension arising from divergence of philosophy. It can also increase the communication among the various disciplines on the staff. Training in a transdisciplinary manner can increase the effectiveness of all staff. As boundaries formed by various backgrounds are eliminated, staff increase their ability to learn from each other in the informal discussions which take place in the everyday functioning

of the program. The development of team functioning is thus enhanced.

3. Early childhood special education is a field in which knowledge is expanding continuously. It is difficult to keep up with all of the new program innovations and research findings. Yet it is important that staff keep current, for example, with changes in theories and intervention strategies in the areas of language, motor, cognition, and social-emotional development as well as family involvement, and program modifications. Programs have a responsibility to children and families to update their staff and incorporate changes which will provide more effective services.

4. Staff development can also increase the skills of paraprofessionals, parents and volunteers who are directly involved in working with children. By expanding their knowledge and skills they may be given greater responsibilities, thereby freeing staff members to increase the amount of time with individual children and families. Staff development for paraprofessionals, parents and volunteers also helps assure that these persons will also be able to provide quality services.

5. Staff development can also increase the self-confidence that staff have in carrying out their various roles. By providing the means by which staff members can increase their knowledge and skills, there is a greater likelihood that staff will find satisfaction with their work. People who feel they are capable and competent in their jobs are also less threatened by working closely with families and other team members.

In the previously mentioned University of Texas Handbook for Facilitators of Staff Development these benefits of staff development are discussed. The following statement from the Handbook nicely summarizes the primary rationale for a commitment to inservice training.

"Staff training that helps the individual become more competent at his job also contributes to self-esteem and to feelings of comfortableness and ease with other staff members. Furthermore, staff training may be utilized as one approach to resolving conflicts and breakdowns in interpersonal relations within a staff. On the whole it can facilitate personal development and maintenance of interpersonal communication" (p 5).

The importance of staff development is illustrated by the specification in P.L. 94-142 that a comprehensive system of personnel development be a component of each State plan.

The primary purposes of this staff development are to

-increase knowledge

-improve performance skills

-change attitudes

-improve interpersonal skills

To accomplish these purposes a planning process which is very well known to special educators is once again put to use. (See Figure 1 p. 303)

I. The knowledge attitudes and skills which are needed by staff are identified.

II. Staff are assessed to determine their strengths and weaknesses in relation to the identified standards.

III. Prescriptions for growth and development are written to improve areas of weakness.

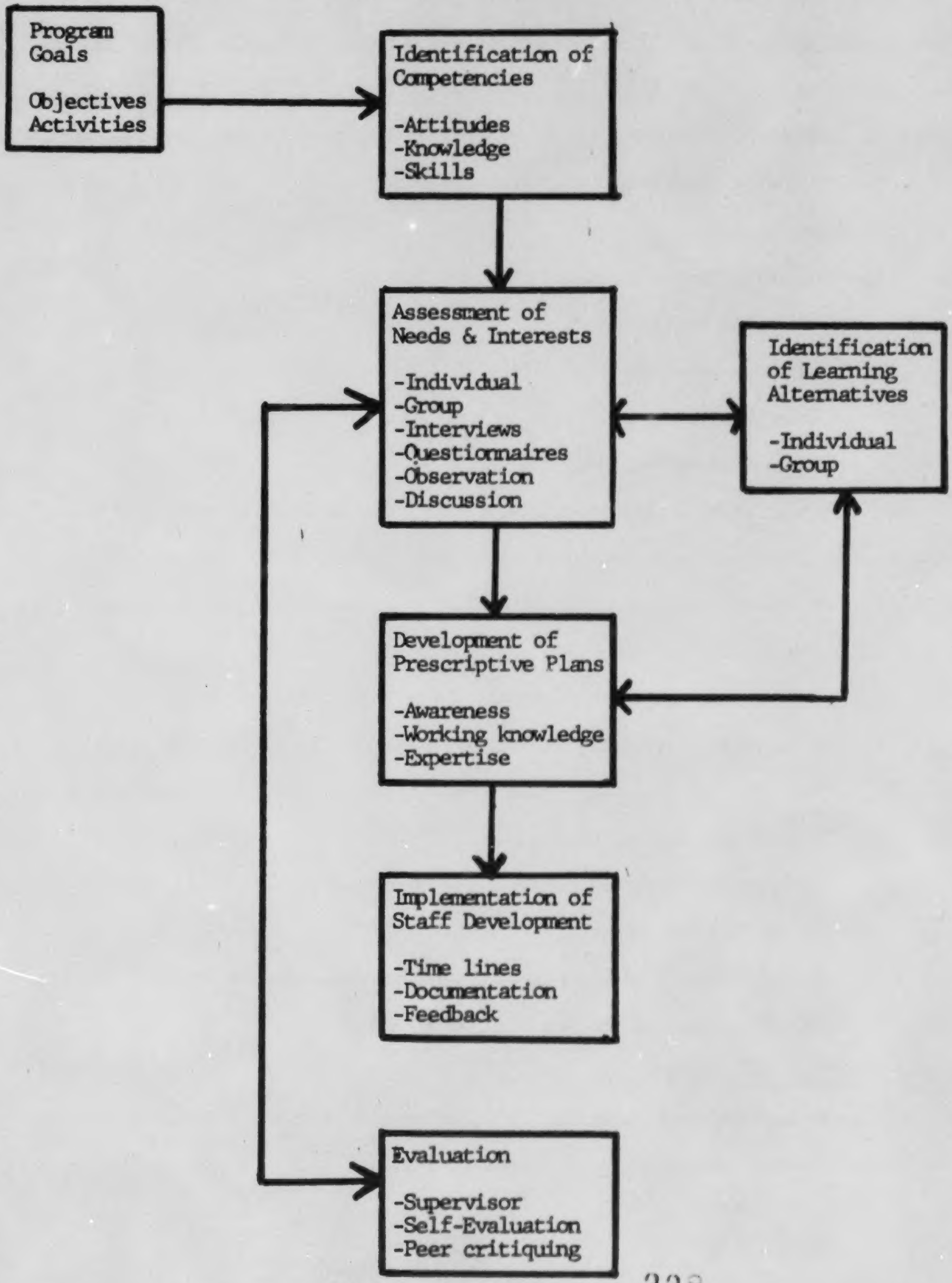
IV. Learning alternatives are which will enable staff to acquire competencies are carried out by staff.

V. Evaluation is done to determine whether objectives have been met and what direction future training will take.

Determination of Competencies

How do we know what knowledge, attitudes, and skills are most important to staff working with young handicapped children? This is a difficult question.

Figure 1, Staff Development Process Model


Program Goals
Objectives
Activities
Identification of Competencies
-Attitudes
-Knowledge
-Skills
Assessment of Needs & Interests
-Individual
-Group
-Interviews
-Questionnaires
-Observation
-Discussion
Identification of Learning Alternatives
-Individual
-Group
Development of Prescriptive Plans
-Awareness
-Working knowledge
-Expertise
Implementation of Staff Development
-Time lines
-Documentation
-Feedback
Evaluation
-Supervisor
-Self-Evaluation
-Peer critiquing

Competency-based education has become popular in recent years. A competency-based (or performance-based) preparation is one in which "... performance goals are specified, and agreed to, in rigorous detail in advance of instruction. The student must either be able to demonstrate the abilities or perform job tasks.... Emphasis is on demonstrated produce or output" (Elam, 1971, p. 1-2).

One advantage of competency-based inservice is that it provides a fundamental reference for planning and individualizing training. It also aids in determining priorities for inservice. Competency based inservice can also become a vehicle to active practical application of knowledge (Falkenstein, 1977).

The issue of teacher competencies has been addressed by many researchers during the 1970's (Altman and Meyen, 1974; Bullock, Dykes, and Kelley, 1975; Fredericks, et. al., 1977; and Rosner, 1974). The study of what competencies are important for working with young handicapped children has been addressed more recently (Garland, 1978; Klein, 1978; Linder, 1980). Competencies, which have been identified derive from three basic sources: 1) Experts in the field of early childhood special education and experienced teachers and support staff have contributed their opinions based on observation, experience and research; 2) Evaluation data from parents and program supervisors provides some information on what attitudes and skills contribute to a successful program; and 3) The literature on important concerns and successful methods and practices provides additional input on needed competencies.

Review of information from all of these sources reveals concensus regarding general areas of significance for training. Messick (1975) identifies these areas as:

-evaluation

-planning instruction

-managing instruction

-communicating

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-human relations

-instructional resources

-institutional administration

The unique nature of early childhood special education programs also necessitates that inservice take into consideration 1) a noncategorical approach to children; 2) the wide range of ability levels among children; 3) a need for transdisciplinary training; and 4) a need for training professionals to work with families as well as children; 5) a need for training professionals to work with social service systems.

This last concern has been viewed as an area which demands special attention in inservice training. Klein, et.al (1978) have identified six competency areas for training staff to work with families.

I. Self & Human Relations

II. Communication & Group Process

III. Individual Development & Exceptionalities

IV. Family Systems & Family Involvement

V. Crisis Intervention & Problem Solving

VI. Work Environment & Human Service Systems

Many universities have also developed competency-based pre-service training programs. These competencies can serve as a foundation for planning an inservice program. Competencies can be added or deleted as necessary to meet individual program training needs. Linder (1980) conducted a nationwide study of one hundred and sixty-two service programs, training programs, and state departments of education, surveying the skills respondents felt were needed by professionals in early childhood special education. Competency areas addressed included: assessment, program and strategies, working with parents, specific knowledge, and leadership. Respondents were requested to rate each competency as to its importance to early interventionists on a Likert scale from one to five, with five being the highest rating. Figure 2 delineates the top three rankings per area, without duplication of competencies. (Overlap of skills between areas did occur.)

The competencies which have been rated as priorities could be considered as a minimum for initiation of planning for inservice training. A detailed list of competencies can be derived from existing competency lists or developed by an individual program.

Figure 2. Competency Rankings by Area

Competency Area	Priorities	Competency
Assessment	(1)	Ability to communicate findings to parents and related professionals.
	(2)	Ability to design individual programs based on assessment data.
	(3)	Ability to integrate findings derived from observation, interviews, records, and assessment; and to state conclusions.
Program and Strategies	(1)	Ability to implement both individual and group instruction.
	(2)	Ability to work with an transdisciplinary team.
	(3)	Knowledge of appropriate curricula

Figure 2. (Cont.)

Competency Area	Priorities	Competency
Working with Parents	(1)	Ability to include parent in child's program.
	(2)	Ability to conduct group sessions in counseling or training.
	(3)	Understanding of interpersonal dynamics, ability to develop effective communication channels.
Specific Knowledge	(1)	Knowledge of handicapping conditions.
	(2)	Knowledge of the rationale for early intervention.
	(3)	Knowledge of and ability to utilize community resources.
Leadership	(1)	Ability to advocate for children and their families
	(2)	Ability to provide guidance to and train paraprofessionals and volunteers.
	(3)	Ability to consult with regular preschool teachers and other professionals.

ASSESSMENT OF STAFF NEEDS

After determining what are appropriate targets for inservice training, it is necessary to ascertain the functional level of competency of staff in relationship to the desired level of competence. A system needs to be devised to objectively assess the knowledge, attitudes and skills of staff and others receiving training. Ideally, inservice should be individualized and based on singular personnel needs. Perrone (1976) has noted that problems with traditional inservice activities include the fact that they are too general; they are geared for groups rather than individuals; and they address perceived rather than actual needs. For inservice activities to be meaningful, it is important that staff be involved in identifying their own needs and help in structuring alternatives for growth. Yeatts (1976) states "teachers will take reform most seriously when they are, at least partially responsible for defining their own educational problems, delineating their own needs, and receiving help on their own terms" (p. 417).

By developing a system which takes into consideration subjective self-evaluation as well as objective supervisory evaluation, staff development can become more meaningful.

Methods for obtaining information about staff levels of competence and need for further training may come from various sources. Background, experiences and training should be discussed with each staff member in an interview. Questionnaires may be developed to give staff an opportunity to express their interest in training in specific areas. In addition, the coordinator and other team members can make several observations of staff performance in the program with checklists relating to the competencies. The assessment should also provide a method for determining strengths as well as weaknesses. Utilization of the strengths within the team enables the supervisor to develop more efficient training as well as provides a means of reinforcing quality performance.

The following needs assessment (Linder, 1980) allows the supervisor, the staff member, or colleagues to assess levels of competence in specific areas. The competencies may be modified as necessary for individual program differences. It also can function as a formative and summative evaluation measure. Different colored pens or pencils are used at midyear and year-end conferences. Thus, improvement, lack of growth, or even loss of skills is clearly visible. The usefulness for program planning and evaluation is clearly apparent. The instrument can be adapted and modified as program focus or staff needs change.

Skills which are rated 1 or 2 indicate areas of weakness needing further development. A "3" is an average ability, and depending on the competency may be adequate or just need some additional work. Ratings of "4" or "5" indicate strengths, with "5" indicating expertise.

Competencies can also be rated by the level of training which is needed. A level of awareness (A), working knowledge (K), or expertise (E) may be needed. Particularly in a transdisciplinary model, the level of knowledge and skill needed by each team member may be different.

The competencies which have been ranked "1" or "2" are then prioritized by the person completing the form in relation to immediacy of need for training Items which are marked "5" are noted as particular strengths.

The last column of the form is utilized for planning of learning alternatives to increase knowledge and skills. The items which have been prioritized as "1" or "2" should be addressed first.

NEEDS ASSESSMENT OF STAFF DEVELOPMENT

Initial Assessment Date ____ Color Green Staff Member ____
Midyear Assessment Date ____ Color Yellow Person Completing Scale ____
Year End Assessment Date ____ Color Red

1) For each of the competencies listed below, rate the staff member being rated (or yourself) on a continium from one to five. A rating of

1 = this is a very weak skill (observed less than 25% of the time)
2 = this is a weak skill (observed 25-50% of the time)
3 = this is an average skill and could use some improvement (50-75% of the time)
4 = this is something the person does well (75%-90% of the time)
5 = this is a skill which is a real strength (is observed 90%-100% of the time)
NA = Not applicable
NO = No opportunity to observe

2) After each competency marked 1, 2, or 3 indicate whether their is a need for training at the level of A = awareness, K = working knowledge or E = functional expertise.

3) After ranking all competencies, go back through the scale and prioritize (with 1 being the highest priority) those items marked as 1 or 2, according to the felt need for immediacy of training.

4) Also rank any items marked as 5 which you feel the person has the ability to contribute to the training of other staff members.

5) After discussion with the supervisor, fill in the Staff Development Column with the planned activities for increasing knowledge or skills along with projected timeline for accomplishment.

Competency	Rating Weakness Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
Competency Area: Screening/Assessment							
1. Demonstrates ability to identify different methods of locating children for screening.	NA 1 2 3 4 5 NO						
2. Demonstrates knowledge of screening methods.	NA 1 2 3 4 5 NO						
3. Knowledge of current research on screening.	NA 1 2 3 4 5 NO						
4. Demonstrates skill in interviewing parents during screening.	NA 1 2 3 4 5 NO						
5. Demonstrates skill in recording observations of children during screening.	NA 1 2 3 4 5 NO						
6. Demonstrates ability to accurately record and analyze screening data.	NA 1 2 3 4 5 NO						
7. Demonstrates ability to review screening data with an interdisciplinary team.	NA 1 2 3 4 5 NO						
8. Demonstrates knowledge of normal development in observing and assessing the functioning of children from birth through eight years.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
9. Demonstrates knowledge of etiologies and psychoeducational implications of various handicapping conditions.	NA 1 2 3 4 5 NO						
10. Demonstrates knowledge of terminology used by other disciplines.	NA 1 2 3 4 5 NO						
11. Demonstrates knowledge of the impact of environmental and cultural factors on a child's development	NA 1 2 3 4 5 NO						
12. Demonstrates ability to assess a child's level of functioning using nonstandarized assessment techniques (0-8 years)	NA 1 2 3 4 5 NO						
13. Demonstrates ability to assess a child's level of functioning using standarized assessment instruments (0-8 years)							
gross motor	NA 1 2 3 4 5 NO						
fine motor	NA 1 2 3 4 5 NO						
language	NA 1 2 3 4 5 NO						
cognition	NA 1 2 3 4 5 NO						
social/emotional	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
14. Demonstrates ability to integrate findings derived from 1) interviews, records, 2) observation, 3) formal and 4) informal assessment and to state conclusions in written form.	NA 1 2 3 4 5 NO						
15. Conclusions at staffings and to state.	NA 1 2 3 4 5 NO						
16. Demonstrates an ability to coordinate and conduct a staffing in such a manner that it is comprehensive comfortable and practical.	NA 1 2 3 4 5 NO						
17. Demonstrates an ability to share assessment information in a manner that can be understood by all present at the staffing. (uses functional examples of behaviors).	NA 1 2 3 4 5 NO						
18. Involves parents in all stages of the staffing, including the development and approval of the I.E.P.	NA 1 2 3 4 5 NO						
Competency Area: Program and Strategies							
19. Demonstrates an ability to plan educational programs, both long-term (annual) and short-term (weekly), on the basis of assessment and environmental data and parental input.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
20. Demonstrates an ability to write instructional objectives in which outcome criteria are specified.	NA 1 2 3 4 5 NO						
21. Is able to develop and modify daily lessons based on assessment and observational findings.	NA 1 2 3 4 5 NO						
22. Writes instructional sequences and activities so that parents and paraprofessionals can follow them.	NA 1 2 3 4 5 NO						
23. Demonstrates an ability to task analyze skills to be taught to the child when necessary.	NA 1 2 3 4 5 NO						
24. Is aware of and utilizes appropriate curricula in planning appropriate strategies.	NA 1 2 3 4 5 NO						
25. Is able to evaluate activities to assess how well lesson objectives have been met.	NA 1 2 3 4 5 NO						
26. Is able to incorporate input from other disciplines into the child's program.	NA 1 2 3 4 5 NO						
27. Is able to modify lessons, response mode, and difficulty level to accommodate the handicap of the child, his input and interests and unexpected events.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
28. Demonstrates an ability to define a rationale and implement procedures for remediation of deficits or delays in the following areas:							
gross motor	NA 1 2 3 4 5 NO						
fine motor	NA 1 2 3 4 5 NO						
oral motor	NA 1 2 3 4 5 NO						
self-help	NA 1 2 3 4 5 NO						
cognition	NA 1 2 3 4 5 NO						
receptive language	NA 1 2 3 4 5 NO						
expressive language	NA 1 2 3 4 5 NO						
social and emotional growth	NA 1 2 3 4 5 NO						
health and nutrition	NA 1 2 3 4 5 NO						
29. Demonstrates ability to locate, develop and/or construct materials for use with a specific child or group of children to achieve given instructional objectives.	NA 1 2 3 4 5 NO						
30. Demonstrates the ability to develop and implement a contingency reinforcement system for use with individual children as needed.	NA 1 2 3 4 5 NO						
31. Records complete concise data on the child's progress toward stated objectives.	NA 1 2 3 4 5 NO						
32. Demonstrates the ability to include parents as an integral part of the child's program.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
33. Is able to coordinate individual educational and therapeutic programs and activities of the various team members into a comprehensive and consistent plan.	NA 1 2 3 4 5 NO						
34. Demonstrates an ability to develop and implement activities which are appropriate for home and center programs.	NA 1 2 3 4 5 NO						
35. Demonstrates knowledge of and ability to plan and implement formative and summative program evaluation.	NA 1 2 3 4 5 NO						
36. Demonstrates ability to monitor the progress of children and staff toward meeting program goals.							
37. Able to plan safe, appropriate early childhood environments using space, equipment and materials to foster cognitive, language, self-help, social-emotional, and motor development to meet individual goals.	NA 1 2 3 4 5 NO						
38. Is able to articulate criteria for selecting curricula, methods and materials appropriate for infants and /or pre-school age children.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
39. Is able to write plans for activities, lessons, and units for groups of children in appropriate development areas at the infant and/or pre-school levels.	NA 1 2 3 4 5 NO						
40. Can individualize for children within a group.	NA 1 2 3 4 5 NO						
41. Demonstrates ability to group children according to appropriate criteria.	NA 1 2 3 4 5 NO						
42. Includes cross cultural considerations in devising and implementing plans.	NA 1 2 3 4 5 NO						
43. Maintains appropriate records and adheres to confidentiality policies.	NA 1 2 3 4 5 NO						
44. Demonstrates skill in utilizing a variety of behavioral and effective approaches to the management of children's behavior at the infant and/or preschool level.	NA 1 2 3 4 5 NO						
45. Demonstrates an understanding and skill in interpersonal communication dynamics with children, parents, professionals, and others.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
Competency Area: Working with Parents							
46. Demonstrates skill in discussing with parents: the needs of the family	NA 1 2 3 4 5 NO						
the functioning levels of their handicapped child	NA 1 2 3 4 5 NO						
specific problems or deficits	NA 1 2 3 4 5 NO						
remediation strategies.	NA 1 2 3 4 5 NO						
47. Listens to parents responses and demonstrates empathy for parents feelings and problems.	NA 1 2 3 4 5 NO						
48. Demonstrates skill in offering parents appropriate suggestions for facilitating their handicapped child's growth and development through play activities.	NA 1 2 3 4 5 NO						
49. Provides written home programs for parents which are appropriate in level and functionality for both the child and the parents.	NA 1 2 3 4 5 NO						
50. Demonstrates ability to instruct parents in developmental, nutritional and health related aspects of education	NA 1 2 3 4 5 NO						
51. Demonstrates skill in counseling parents and/or siblings regarding problems related to having a handicapped child in the family, and can deal effectively with crisis.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
52. Individualizes the program for families depending on their needs and desires, strengths and limitations.	NA 1 2 3 4 5 NO						
53. Guides parents in the selection or creation of materials and toys for their handicapped child.	NA 1 2 3 4 5 NO						
54. Demonstrates an ability to conduct parent discussion groups.	NA 1 2 3 4 5 NO						
55. Demonstrates an ability to provide parent education information to parents through a variety of channels.	NA 1 2 3 4 5 NO						
56. Is able to conduct home visits in a manner which takes, into consideration the total family's needs.	NA 1 2 3 4 5 NO						
57. Is able to refer parents to appropriate community services when necessary.	NA 1 2 3 4 5 NO						
Competency Area: Leadership: 58. Demonstrates an ability to train parents, professionals, and paraprofessionals in educational procedures, such as observing and assessing the child, and planning, implementing and evaluating a program.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
59. Demonstrates an understanding of regular preschool classroom operation.	NA 1 2 3 4 5 NO						
60. Is able to plan and conduct effective in-service training activities for regular pre-school teachers.	NA 1 2 3 4 5 NO						
61. Demonstrates skill in interacting and counseling regular preschool teachers.	NA 1 2 3 4 5 NO						
62. Uses appropriate techniques such as modeling, prompting, assisting, cueing, to train others in new skills.							
63. Uses effective measures to provide feedback and reinforcement to persons being taught new skills.	NA 1 2 3 4 5 NO						
64. Demonstrates skill in acting as a liaison between persons, groups, or agencies regarding problems relating to handicapped children.	NA 1 2 3 4 5 NO						
65. Demonstrates an understanding of the total service delivery system and is able to work effectively within the system as a change agent.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
66. Is able to evaluate staffing needs with regard to the number and type of children being served and the type of program model being implemented.	NA 1 2 3 4 5 NO						
67. Is able to define and describe various role descriptions within the program.	NA 1 2 3 4 5 NO						
68. Is able to define criteria for hiring staff.	NA 1 2 3 4 5 NO						
69. Is able to develop formative and summative evaluation measures for children, staff and the total program.	NA 1 2 3 4 5 NO						
70. Is able to plan for individualized development, establishing criteria for determination of needs and value of training.	NA 1 2 3 4 5 NO						
Competency Area: Knowledge: 71. Demonstrates knowledge of the rationale for early intervention.	NA 1 2 3 4 5 NO						
72. Demonstrates knowledge of agency goals, funding sources, services, and personnel.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
73. Demonstrates knowledge of community services, agencies, and resources important to early childhood special education programs.	NA 1 2 3 4 5 NO						
74. Demonstrates knowledge of state and federal litigation and legislation regarding education of exceptional children.	NA 1 2 3 4 5 NO						
75. Demonstrates knowledge of alternative models, program designs, curricula, methods and materials appropriate for young handicapped children.	NA 1 2 3 4 5 NO						
76. Demonstrates knowledge of research relevant to the development and education of handicapped children.	NA 1 2 3 4 5 NO						
77. Demonstrates knowledge about concepts of sociology of the family, family development, and family relationships.	NA 1 2 3 4 5 NO						
Competency Area: Affect 78. Demonstrates enthusiasm when working with children and families.	NA 1 2 3 4 5 NO						

Competency	Rating Weakness/ Strength	Indicate Level of Training Needed and Priority of Need				Prioritize Strengths for team sharing	Methods for Staff Development
		A	K	E	Priority		
79. Demonstrates confidence and composure in maintaining the learning environment.	NA 1 2 3 4 5 NO						
80. Demonstrates patience and understanding toward children and families.	NA 1 2 3 4 5 NO						
81. Assumes initiative and responsibility for accomplishing necessary program tasks.	NA 1 2 3 4 5 NO						
82. Utilizes constructive feedback for personal growth and development.	NA 1 2 3 4 5 NO						
83. Recognizes and expresses need for skills and information and seeks staff development activities.	NA 1 2 3 4 5 NO						
84. Shares ideas and skills with other staff	NA 1 2 3 4 5 NO						
85. Exhibits honest respect for							
children	NA 1 2 3 4 5 NO						
families	NA 1 2 3 4 5 NO						
staff	NA 1 2 3 4 5 NO						
86. Accepts responsibility for own actions.	NA 1 2 3 4 5 NO						
87. Can examine own value system critically.	NA 1 2 3 4 5 NO						

NEEDS ASSESSMENT

When a supervisor or colleague utilizes an assessment instrument, care should be taken that several observational opportunities be planned prior to filling out the forms. Being rated by colleagues can be extremely threatening and could perhaps be done as a team "self"-assessment rather than peer rating peer.

After completing the self assessments and supervisory assessments Garland (1978) recommends constructing needs assessment grids. A grid can be developed for each competency area, listing each competency down the side and the rating across the top. The supervisor then tabulates how many staff members have been rated at each level for each competency. See Figure 3. It may be desirable to develop separate grids for information obtained from self-assessments and another for ratings done by the supervisor. This may help the supervisor to see patterns of variant perceptions.

Figure 3. Needs Assessment Grid

Area - Assessment

Competency	NO	NA	1	2	3	4	5
Can develop lesson plans based on assessment findings				1	3	2	
Can task analyze skills to be taught to the child			1		1	4	
Can evaluate activities to assess how well lesson objectives have been met				4	1		1

In this section of the grid, it can be seen that there is some need for training with each of the competencies. The ECH coordinator can look at the overall grid and determine where there is a need for group training and where individual activities are appropriate. For example, in Figure 3 the ECH coordinator could determine that most of the staff, with one exception, can plan their activities for children based on assessment findings and, can task analyze skills. The coordinator can work singularly with that one staff member, represented as a 1 in the grid square, on options to develop this skill. The coordinator can also see that four persons have deficient skills in assessing the accomplishments of children during a lesson. Some type of group learning experiences can then be planned to help staff develop these observational and record keeping skills.

Prescriptive Planning

After the needs assessments are completed and the grid summarizing the information is completed, planning for individual and group staff development activities can begin. The ECH coordinator, when consulting with each individual staff member, will go over the needs assessment form filled out by the staff member. The coordinator's perceptions of strengths and weaknesses can be discussed at the same time. Objective data obtained through observation should be used whenever possible. Together the coordinator and staff member determine competency areas on which to focus during the year. Priorities for individual training may be selected by examining priority rankings marked on the needs assessment form. If the supervisor's and staff members needs and priorities differ, negotiation can then take place. It is often wise to let the staff member select one area on which to concentrate first. Motivation to change is often facilitated by the element of self-determination. However, some competencies are sequencial and prerequisites must be addressed first. Also program priorities may dictate the sequence.

After targeting the priority competencies for professional growth, the staff member and the ECH coordinator can work together to determine the best methods by which to accomplish the attainment of these objectives. A suggested timeline should also be discussed and at least tentatively planned.

The ECH coordinator can also summarize data from the strengths column of the needs assessment form. It is important that staff members get feedback from the supervisor to reinforce the strengths that are observed. This information will also prove useful as a beginning point for coordination of training resources. By utilizing internal staff as resources whenever possible, self-confidence is strengthened and training money can be used for needed external resources, thereby expanding training potential. Staff also deserve recognition for the knowledge and skills which they have demonstrated in the program.

Group Needs

The staff as a whole or a sub-committee of staff representatives may be used to help analyze the assessment grid for group training needs and to assist in planning for the more global concerns. They can look for sets of skills which may need to be addressed in combination and make sure that planned activities are relevant. Priorities for group training efforts can be determined by examining the needs assessment grid for squares with large numbers in the "1" and "2" columns. The ECH coordinator can then select those areas that are most important for effective program functioning. For example, assessment concerns may be more relevant at the beginning of the year than some less immediate concerns which could be addressed later in the year.

Planning Learning Alternatives

There are innumerable ways in which knowledge and skills may be acquired. The accumulation and coordination of a variety of resources for staff development is an important function of the coordinator.

The primary responsibility of the staff development coordinator then becomes "matching the identified prioritized staff development needs with appropriate and available experiential and educational resources." (Klein, 1978, p 27). Provocative and challenging experiences will help motivate staff. The coordinator needs to be able to provide aid, resources, and materials to encourage continued growth. The entire community may be utilized as a resource. The possibilities for learning alternatives are only limited by the creative imaginations of the coordinator and staff.

In choosing methods for accomplishing stated staff development objectives, it is important to consider a training hierarchy. Particularly in a trandisciplinary program model, not all staff members need the same level of competence. It has been suggested that three levels of competence be considered in planning for training:

-awareness

-working knowledge

-expertise
(Illinois Department of Specialized Education Services, 1979)

For instance, in an early intervention program with motorically involved or delayed children, it is imperative that the occupational or physical therapist have expertise in reflexes, motor development, and intervention techniques for young handicapped children. The other members of the transdisciplinary team need a working knowledge of reflexes, motor development and intervention techniques so they can follow through on recommended strategies. The principal of the school needs an awareness of the importance of reflexes, motor development and intervention techniques so he can justify the hiring of an occupational or physical therapist for the program. The implications for training at these various levels are obviously different. The staff development coordinator needs to plan for the various levels training required. In addition, those individuals with demonstrated levels of expertise need enrichment opportunities through staff development. By offering a diverse range of options for individuals and groups to acquire knowledge and skills at levels of awareness, working knowledge, expertise and enrichment, coordinator can personalize staff development. Figure 4, pages 329-330, describes various learning alternatives and designates whether an alternative is appropriate for an individual or a group and what level of training can be accomplished by the method.

Seminars, lectures, courses, and conferences are appropriate for group training efforts. They can provide basic current information, and with good presenters or speakers can be very stimulating. Follow-up application of information is usually lacking.

Discussion groups, simulations, demonstrations, workshops are usually more active and involve application of knowledge to specific situtations. However, they tend to be short "one-shot" activities again usually lacking follow-up. Other group activities, such as curriculum and materials development may be long term projects.

Falkenstein (1977) recommends that whenever possible community resources should be used in an "action learning model". Internships in professional, business, political, or civic situations can provide valuable learning experiences which may also have the added benefit of building community awareness and support. Staff exchanges and other on-the-job training experiences can be very effective with planning, support and follow-up. Learning by "doing" as utilized in demonstration and practice workshops, simulations, tapings and in-classroom consultation can also provide opportunities for immediate feedback which is so important to learning.

Classroom research is another infrequently utilized approach to staff development which can assist staff in determining effective training techniques. Individual activities such as reading specific materials, keeping goal-directed journals, working at teacher centers, or observing and discussing new methods

Figure 4. STAFF DEVELOPMENT ALTERNATIVES AND EVALUATION METHODS

Learning Alternatives	Appropriate for Individual	Appropriate for Group	Level of Competence Acquired				Evaluation Methods									
			Awareness	Working Knowledge	Expertise	Enrichment	Pre/post test	Interaction Analysis/ Observation	Discussion	Journal	Report	Product	Data	Video/Audio Tape	Peer Critique	**Other**
Seminar	X	X	X	X		X	X		X	X						
Lecture	X	X	X			X	X		X	X						
Discussion		X	X	X				X		X						
Conferences	X	X	X			X			X	X	X					
Workshops	X	X	X	X		X	X	X	X	X	X	X	X			
Audiovisuals	X	X	X	X			X	X	X					X	X	
Demonstrations	X	X		X	X		X	X	X				X	X	X	
Site Visits	X	X	X			X			X	X	X					
Role Plan/ Simulation	X	X	X	X	X			X	X					X	X	
Consultation	X	X		X	X		X	X	X				X	X	X	
Curriculum Development	X	X		X	X	X						X	X			
Courses	X	X	X	X	X	X	X	X	X	X		X	X			

Figure 4. STAFF DEVELOPMENT ALTERNATIVES AND EVALUTATION METHODS

Learning Alternatives	Appropriate for Individual	Appropriate for Group	Level of Competence Acquired				Evaluation Methods									
			Awareness	Working Knowledge	Expertise	Enrichment	Pre/post test	Interaction Analysis/Observation	Discussion	Journal	Report	Product	Data	Video/Audio Tape	Peer Critique	Other
Holding organizational office	X			X	X	X			X		X	X	X			
Conducting Workshop	X				X	X			X				X			
Publishing articles	X	X			X	X						X	X			
Developing materials	X	X		X	X	X						X				
Lecture series	X			X	X		X		X	X	X					
Travel	X	X	X	X		X				X	X					
Readings	X	X	X	X		X	X		X	X	X					
Classroom Research	X	X		X	X	X		X		X			X			
Classroom Journal	X			X					X		X	X	X			
Work sessions at Teacher center	X	X		X	X			X				X				
Training on the job	X			X	X		X	X	X	X	X	X	X	X	X	
Internship	X			X	X		X	X	X	X	X	X	X	X	X	
Teacher - exchange	X			X	X		X	X	X	X	X	X	X	X	X	

with collegues can be rewarding under facilitative guidance.

For those with a high level of expertise in most competency areas enrichment activities and involvement in leadership can be rewarding. Conducting workshops, planning conferences, holding professional office, publishing articles, and assisting with staff development can provide means for continual growth and professional development.

The most commonly used staff development alternatives such as lectures, courses, workshops and conferences are primarily for developing "awareness" and a working knowledge of a topic. They can be made more effective by combining other alternatives to supplement the activity in order to develop the needed "expertise". For example, in an inservice workshop in which staff are learning about reflexes and positioning techniques, staff might also 1) be provided with relevant readings, 2) observe an O.T. or P.T. doing an individual assessment and working with a child, 3) do simulations with dolls, or 4) help keep a journal of their observations of their children's performance when in different positions in a classroom or in the home. Follow-up is also essential if actual transfer and generalization is to take place. It is suggested that some type of follow-up consultation take place to provide feedback and reinforcement to the staff. This can be done through direct consultation in the classroom, or by videotaping staff with children and families and reviewing the tapes in later individual or group problem-solving sessions.

A very effective personalized staff development plan can be developed by carefully assessing the level of staff needs and then working together to determine what combinations of activities will lead to the achievement of stated objectives. It is emphasized that staff development activities should be viewed holistically rather than as a fragmented, isolated events. A transdisciplinary, ecological approach to training is recommended.

There are advantages and disadvantages to each alternative, so it is important that in the case of individual staff needs each option be carefully discussed. The specifics of what is to be accomplished and how it will be accomplished need to be given careful consideration and put into writing. For group efforts it is necessary for careful planning with staff input to take place.

In the process of determining which alternatives are the most appropriate consideration should be given to the following:

1) efficiency and effectiveness
2) cost-effectiveness
3) interest level
4) motivational factors/reinforcement
5) necessary prerequisite knowledge on skills
6) support needed
7) time involved
8) need for follow-up
9) scheduling problems
10) generalizability
11) staff supervision time required
12) special equipment or materials necessary
13) individual learning styles
14) available resources

EVALUATION

Application of knowledge and skills is the ultimate goal of staff development, most planned activities need to result in some observable change in behavior. Demonstration and verbalization of new or better competence on the part of staff members is an indication of successful staff development.

When the coordinator and staff member are meeting to discuss the needs assessment and planning the learning alternatives in which the staff member will participate, it is also important to plan how growth will be evaluated. Each staff member needs to be responsible for recording his/her own progress toward the mutually determined objectives. Regularly scheduled supervisory sessions may also be outlined. These sessions may involve observation of the staff member while on the job with a review meeting afterwards. Informal ongoing discussions of progress can also be effective. The coordinator/supervisor must maintain an atmosphere which is supportive of growth rather than demanding or threatening.

Figure 4 on pages 329 and 330 delineates a variety of evaluation methods that might be used to assess progress for each of the learning alternatives presented. Again various combinations of techniques may be desirable.

One of the most commonly utilized methods of evaluation is the pre/post test. This type of assessment is effective in measuring change in the level of knowledge on a particular subject, but usually does not reveal whether the information is able to apply to work situations. These type of tests are given right before and after a training session and are usually limited to short answer responses which do not adequately assess integration of information or long term retention of information. They are quick and easy to administer, and criterion for success are easily established. However, most staff do not like taking tests.

Another method of assessing a group is by follow-up discussion. New awarenesses and application of principles can be informally shared in problem solving sessions. The coordinator can observe changes in attitude and application of knowledge by directing discussion of issues to the application to the program. For example, after an inservice on the importance of parent involvement, the coordinator might follow -up with a staff discussion on parent involvement in their program. Staff could be called upon to apply new knowledge by planning for changes in the existing program. By listening to staff input the coordinator can informally assess each staff members attitudes and ability to apply the new information. Additional staff development activities on parent involvement may then be added as needed.

Individual or small group discussions with the coordinator can also provide informal assessment for staff when the total staff is not participating in the inservice activities. Discussions can be quite supportive and can allow for application of knowledge. They are also less threatening than tests.

When specific skills are being learned an interaction analysis model is often helpful. The coordinator use a checklist or observational guide to assess the behaviors which the staff member is demonstrating. Interaction analysis is particularly useful for evaluating interpersonal interactions between a child and a staff member, a staff member and a parent, or staff members with each other. For example, after a series of inservice workshops on communication skills in which participants have read materials, listened to lectures, viewed video tapes, and simulated conferences, the coordinator should evaluate staff members acquired "expertise". By observing actual conferences between staff members and parents, or viewing a video tape of the conference, or listening to an audio tape the coordinator can assess the degree to which staff members demonstrate the necessary skills. The staff member can then either be congratulated for utilization of good communication skills or, if inadequate skills are demonstrated, be channeled into further staff development activities.

Utilization of logs or staff journals is an effective way for staff to be involved in their own assessment. By keeping a journal on daily activities staff can document growth toward development a particular process, skill.

Often staff do not realize the changes which occur over time. A journal can help staff to do a self-analysis of strengths and weaknesses as well as a self-assessment of progress toward objectives. It is important that the staff member be given enough information and guidelines on what to document. If, for instance, a staff member is working on improving behavior management techniques in the classroom, the coordinator might provide guidelines on the types of information to include in the journal - size of groups, constellation of groups, time of group activities, antecendents to consequences of negative behaviors, etc. Ongoing conferences with the supervisor to discuss the material in the journal is important to facilitate problem-solving and continued growth.

Much information can be gained through site visits, travel, attending conferences external lecture series and workshops, seminars and university course work. Whenever possible this information should be shared with other staff. When making site visits or traveling to other locations to observe different programmatic approaches, it is useful to develop the objectives of the visit, develop questions and an observation guide ahead of time. The information gained is then easily summarized. Knowledge gained through external, structured formats can either be assessed by observation of acquired skills or through informal seminars on site. Much of the information gained at conferences, seminars, etc. helps staff gain the "working knowledge" of a topic. It is appropriate for them to demonstrate this new knowledge in some way which is meaningful. Preparation of a inservice workshop on the topic can help staff to consolidate and integrate new information more fully. Staff evaluation of the workshop or training session can constitute assessment of competence.

The development of products for use in the program is another means of evaluation. Depending on the knowledge and skills which have been targeted, the following examples of products might serve as evaluation of growth:

-curricula

-specialized toys, games, or materials

-specialized equipment

-a slide tape show or film strip

-a video tape

-parent information packets

-parent education modules

The effectiveness of the product when used within the program can serve as the measure of success.

The on-going collection of data with respect to a particular staff development objective is another method which can be used to evaluate professional change. Many different forms of data collection can take place. Gathering baseline data and charting increases or decreases in behavior can be done by staff on themselves as well as on their children. Other forms of data can be collected with regard to

-time spent with individual children

-time spent with groups

-number of skills developmentally

-sequenced or task analyzed

-number of contacts with parents

-amount of communication with team members

-time spent on various activities

-etc.

The coordinator/supervisor can help staff to select program facets which can be measured and analyzed. After desired changes are determined and plans for change implimented, continuous or probe data collection methods can be instituted to record progress. Involving staff in the data collection process makes the information more meaningful and also serves as a motivational factor.

Video tapes or audio tapes can serve as both pre-and post-test measures as well as training methods. Audio-visual methods are invaluable and whenever possible should be utilized in conjunction with other methods for both planning, implementing, and evaluating professional growth plans. The team should also be used in much the same way. They can act as a support system and also provide clinical evaluation through peer critiquing of specific skill areas. For example, the speech therapist on the team can help identify targets for improvement for other team members in the area of speech and language. He/She can also help plan and carry out inservice training activities. At appropriate times the speech therapist can also help team members to evaluate their professional growth in this area. Often the use of video tapes by team members in the various phases of staff development is an excellent method of both strengthening individual growth and team functioning. Video tapes can also be used to record valuable inservice sessions for future use with other team members or other community agencies.

The optimal staff development assessment plan will incorporate supervisor evaluation, self-evaluation, and colleague critiquing. The appropriate use of each of the previously discussed methods of evalulation by these various program personnel will contribute to a comprehensive evaluation system. Both formative and summative measures of staff development will contribute greatly to the overall program evaluation.

The assessment, planning, implementation and evaluation phases should be an ongoing cycle. Evaluation may reveal the need to return to the planning phase. The staff development process should be viewed as continuous, incremental, and responsive to individual and group needs. Therefore, staff also need an opportunity to have input into the evaluation of the staff development component on a regular basis.

Guidelines for Staff Development

1. Staff development needs to be a fundamental component of the program not an extraneous activity, with a person responsible for coordinating training

who has sufficient time and skills to do a quality job.

2. Staff development should be viewed as a supportive rather than critical approach to individual and group growth.

3. Competency based staff development lends itself to individualization and measurements.

4. Competencies should reflect the all areas of the program and include attitudes, knowledge and skills commensurate with program philosophy and objectives.

5. A wide variety of alternatives should be available for individual and group learning at the levels of awareness, working knowledge, expertise, and enrichment.

6. Staff needs should be identified by a variety of methods, including interview, questionnaires, and observations, as well as group discussion and team observations.

7. Staff should be involved in developing a written plan of learning alternatives appropriate to their needs which will result in professional growth.

8. Staff should be involved in planning evaluation methods as well as documenting their own growth.

9. Provision should be made for debriefing sessions after training and feedback to staff on a regular basis.

10. Time and compensation should be considered in planning for staff development .

11. Staff development also needs to meet the needs of paraprofessionals, volunteers, and parents.

12. Utilization of community resources as well as internal resources can maximize training efforts.

13. An adequate training budget is needed for ongoing staff development.

14. Competence should be rewarded.

15. Staff development should be viewed as an continuous, responsive process.

16. Professionals serving children and families should be involved in training whenever possible.

17. Effectiveness is best evaluated by demonstrated competence.

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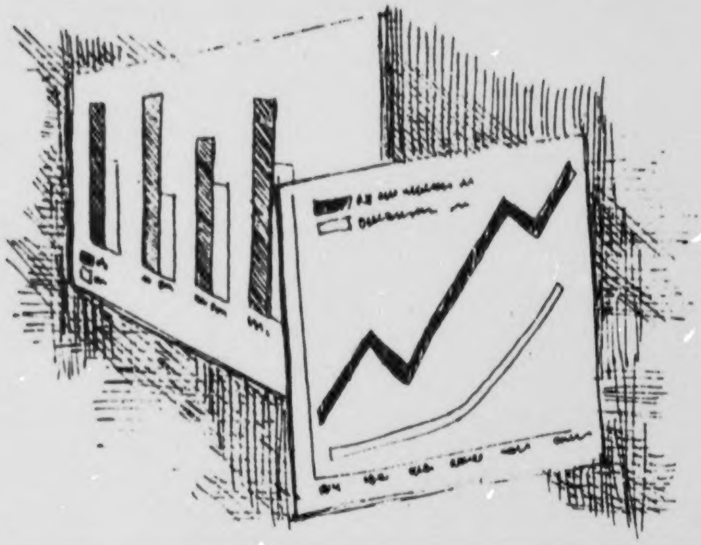

NINE

EVALUATION

"While decisions are (or should be) based on data, decision making is separate from data collection and involves people and values as well as numbers" (Deno and Mirkin, p. 19, 1977).

In days of economic distress it is often human service programs which are cut or reduced. Innovative programs or programs which are not "traditional" components of education, such as early intervention programs are often the target of efforts to eliminate essential programs. Their continuation can only be justified if well planned and comprehensive evaluations have documented their worth and effectiveness. In addition, there is growing concern throughout education for greater accountability to justify expenditures.

Evaluation can be described as the objective judgement of the worth of something, usually in terms of its adequacy, effectiveness or costs. Products, processes or individual performance are usually evaluated in educational programs.

Anderson and Ball (1975) identify six major purposed for program evaluation:

1) to contribute to decisions about programs installation;

2) to contribute to discussions about program continuation, expansion, or certification;

3) to contribute to decisions about program modifications:

4) to obtain evidence to rally support for a program:

5) to obtain evidence to rally oppostion to a program; and

6) to contribute to the understanding of basic psychological, social and other processes.

Renzulli (1975) states that "the general purpose of evaluation is to gather, analyze, and disseminate information that can be used to make decisions about educational programs. Evaluation should be directed toward action that hopefully will result in the improvement of services to students through the continuation, modification, or elimination of conditions which effect learning."(p. 2).

Program evaluation can be thought of as analogue to child evaluation. It should be "diagnostic", indicating the strengths and weaknesses of the program as well as providing the basis of decisions which will lead to positive growth. Toward this end, the purposes of program evaluation as outlined by Renzulli (1975) include:

1) to discover whether and how effectively the objectives of a program are being fulfilled.

2) to discover unplanned and unexpected consequences that are resulting from particular program practices;

3) to determine the underlying policies and related activities that contribute to success or failure in particular areas;

4) to provide continuous in-process feedback at intermediate stages throughout the course of a program:

5) to suggest realistic, as well as ideal, alternative courses of action for program modification (p. 6).

In order to adequately accomplish the above objectives, it is necessary to look at two types of information. Information which is gathered in an ongoing manner or at intermediate stages in order to discover deficiencies and successes is necessary for formative evaluation. Summative evaluation, on the other hand, is concerned with looking at overall program effectiveness. Formative evaluation data is used to measure both the students' and program's progress toward accomplishing their objectives. Summative evaluation data measures the end result of the students' and the program's growth and is used to determine the fate of the program. Figure 1, below, compares the characteristics of these two types of evaluation.

Figure 1

A Comparison of Formative and Summative Evaluation

FEATURE	FORMATIVE EVALUATION	SUMMATIVE EVALUATION
1. Principle purpose	developmental improvement of a program or product	judgment of the overall worth of program or product
2. Schedule of use	continual; data fed back into developmental cycle	normally, when program is completed or product finished; or at go-no go, fund-no fund decision.
3. Evaluative Style	rigorous, systematic diagnosis	rigorous, systematic comparative, or using absolute standards.
4. Normal Evaluators	internal staff or supportive consultants hired by program or product developers	external, non-partisan personnel or internal staff
5. Consumers of evaluation	program designers and staff, product developers, "insiders"	market consumers, funding agencies, "outsiders".

From Handbook for Measurement and Evaluation in Early Childhood Education by William L. Goodwin and Laura A. Driscoll, San Francisco: Jossey-Bass Publishers, 1980. Based on Scriven's model.

Throughout the life of a program, both formative and summative evaluation need to take place. In eary childhood special education it is recommended that the program components be examined using both formative and summative evaluation techniques. Services for children, services for families, staff development are important program components (Suarez and Vanderviere, TADS, 1978).

In addition, coordination of community services and, for grant funded projects, demonstration and dissemination may also be important components to be evaluated. Within each component various models are recommended for structuring the analysis of data. Regardless of the terminology employed, however, most models examine 1) what resources and conditions contribute to program objectives, 2) what events take place to accomplish necessary objectives, and 3) what took place as a result of the program.

Stake (1967) suggests that at each level of evaluation observations and should be compared to the initial intents of the program. The resulting comparative data when analyzed in relation to accepted standards provide the basis for judgments concerning program decisions.

Figure 2

Comparison of Various Models of Evaluation

Component	Stake's Countenance Model	Provus' Discrepancy Evaluation Model	Stufflebeam's Model	Eash's Differentiated Model	Saurez and Vandeviere TADS Model
I. Services for Children	Antecedents	Input	Context Evaluation/Input Evaluation	Effort	Rationale Description
II. Services for Parents	Transactions	Process	Process Evaluation		Reaction
III. Staff Development	Outcomes	Output	Product Evaluation	Effect	Changes
IV. Coordination of Resources					
V. Demonstration/ Dissemination				Efficiency	

Eash (1971) also suggests that the types of data gathered at each level of the models described in Figure 2 will vary depending on the phase of its evolution in which the program is functioning. Differential evaluation would take place in:

1) the "initiatory" stage, when a program is being planned and conceptualized;
2) the "developmental" stage when the program is actually implemented; and
3) the "integration" stage when the program becomes an internal part of the existing program.

Figure 3, page 346 depicts examples of evaluation questions (evaluation concerns in question form) that might be raised at each level in each stage of program evaluation. The model utilized is compounded from elements of the models in Figure 2.

Program evaluation is an integral part of the program and should always be planned prior to the implementation of the project. Several key questions need to be asked at the time of planning for evaluation:

1) Why is the evaluation being conducted?
2) Who will receive the evaluation information?
   (Who are the decision-makers?)
3) What kind of information do the decision-makers need?
   (In what evolutionary stage is the program?)
4) What type of formative evaluation data is needed?
5) What type of summative evaluation data is needed?
6) What instruments are needed to gather necessary data?
7) When should the data be gathered?
8) How will data be analyzed?
9) Who will do the evaluation?

Figure 3

Evaluation at Development Stages Within Each Level*

	Initiatory	Developmental	Integrated
Input	What community agencies have been involved in program planning? What has been the contributions to planning of the various agencies?	What are the program objectives? Where has financial support of the program emanated?	What data is available to document the effect of the program on existing program components? What data is available to assist in long-range planning?
Process	What formal and informal mechanisms have been initiated to ensure comprehensive programs? What have been the impediments to organizing the program?	What have been the activities utilized to meet objectives for children? What have been the activities organized to provide support to parents?	What ongoing mechanisms have been established to ensure quality programs? What plans have been implemented to expand dissemination of program information?
Product	Does the planning committee have a plan of action with a lifetime for activities?	What have been the effects of the program on the children served? What have been the effects of the program on families served?	Is any provision made for studying long term effects? Have there been any unanticipated effects?
Efficiency	Given the amount of time and money invested has a useful product emerged?	How does the cost per child compare to comparable programs in the state?	What is the projection for maintenance of the program?

*Adapted from Eash, 1971

Why Evaluate

The question of why the evaluation is being conducted is important as administrators, staff, parents and outside agencies working with the project will all be called upon to provide data. It is important that all parties concerned understand the rationale for evaluation and perceive its usefulness to them individually. A commitment to follow through on conducting the formative and summative measurements is necessary or the whole evaluation design, and consequently the program, could be destroyed for lack of sufficient data. Just as important is the commitment on the part of all parties, particularly administrators and staff to utilize information gained from evaluations and actually modify programs based on feedback from evaluations. Many times administrators want to see only the evaluation data which is favorable to the existing systems. However, an openness to self-examination which may point out deficiencies or gaps is essential to the development of an effective program.

Who are the recipients of evaluation who will receive the evaluation information, and what will they do with it? The major groups concerned with evaluation results include:

- parents
- staff
- administrators
- school board
- state and/or federal agencies
- community agencies and organizations

Different types of information are of interest to the various groups. For example, parents are not only interested in how much their child progressed; they may also want to know how other parents felt about the program or what modifications are planned to meet their unmet needs. Teachers may want to know what environmental changes would enhance their classroom's effectiveness while speech therapists may want information about the effectiveness of individual versus group instruction. Administrators may be concerned with cost efficiency and program effectiveness as well as staff training needs. The school board may want information on continuation of the program, the implications for long-range planning, as well as consumer satisfaction. Other community agencies may want information relating to overlaps or gaps in service and on the impact of their involvement.

By analyzing the nature of the groups who will receive evaluation data, a comprehensive evaluation design can be planned to encompass the needs of all interested persons and groups. The lack of such thoughtful planning may lead to gathering information for only one group (the funding agency) to the exclusion of others who might be important advocates and support groups at the critical time of the question of program continuation.

Components to Evaluate

As previously mentioned, there are several critical components that need to be addressed in evaluation:

- services to parents
- services to children
- staff development
- coordination of community resources
- demonstration/dissemination (for grant funded projects)

Documentation in these areas is crucial. TADS/WESTAR refer to documentation as "the process of recording the design, activities, and accomplishments of a program. Documentation forms the foundation of a project's evaluation in that it provides both the description of the program and many of the results. It also substantiates the contents of progress reports and continuation proposals. Finally, documentation provides the substance for products, demonstration and information materials which includes brochures, speeches, workshops, and the like" (p. 3).

Suarez and Vandeviere (1978) recommend that documentation in each area should include:

1) the rationale, or the framework for selection of strategies,
2) a description of services provided and their outcomes.
3) the reaction of people to the services, their perceptions of and satisfaction with the quality and quantity of activities.
4) the changes which have occurred in people and/or activities after participation in the project. The following chart, Figure 4, indicates the type of documentation which may be needed in each area.

Types of data needed

The types of formative and summative data needed can be determined by addressing the needs of the decision-making and potential "advocacy" groups and also by examining the stated objectives of the program. Each of the program's objectives need to be addressed in the evaluation plan. A variety of methods may be needed to adequately assess the program's effectiveness in accomplishing its objectives. For example, a program objective might state:

"Ninety percent of the children served will accomplish seventy percent of the stated objectives in their I/E.P.'s without one year."

To adequately evaluate this objective, both formative and summative measures would be needed. During the year, staff should maintain on-going assessment data to enable them to modify the child's program as needed to increase the rate of growth. Summative measures will address the child's total growth at the end of the year.

However, important additional information should also be gained in relation to that objective. For instance,

-What strategies seemed most effective in intervention?
-Did the parents see the same growth at home as the staff did at school? In other words, did the skills generalize?
-What were the problems encountered which hindered growth?

Figure 4

Documentation Needed in Evaluation

COMPONENT	RATIONALE	DESCRIPTION	REACTION	CHANGES
SERVICES TO CHILDREN	1. Document the rationale upon which the services to children are based.	1. Document the criteria for selection of children. 2. Provide evidence that the children served are handicapped. 3. Describe the project children, including their ages and type and severity of handicap. 4. Document the existence, implementation and results of an I.E.P. for each child. 5. Describe the services which were provided. 6. Document the extent to which the stated goals and objectives were attained.	1. Document the parents degree of satisfaction and/or their reaction to project services for their children.	1. Document the progress of children receiving project services using the most reliable and valid measures available.
SERVICES TO PARENTS	1. Document the rationale for services to parents.	1. Describe the services which were provided to parents. 2. Document the extent to which stated goals and objectives for parents were attained.	1. Document the parents' reactions to the program for their children. 2. Document the parents' reactions to the program for themselves.	1. Document changes in parents knowledge and/or behavior during and after participation in the program.
STAFF DEVELOPMENT	1. Document the rationale for the specified staff roles needed to carry out the project activities. 2. Document the existing staff development needs upon which the staff development program is to be based.	1. Document the responsibilities of the staff and their particular training and experience for those responsibilities. 2. Document the activities and outcomes of the staff's orientation to the project. 3. Describe the staff development activities. 4. Document staff involvement in staff development activities. 5. Document the extent to which stated goals and objectives for staff development were attained.	1. Document the staff development activities in which they participated. 2. Document other persons' reactions to the staff in areas targeted for staff development.	1. Document the change in staff members knowledge competencies and/or behavior after participation in the staff development program.
COORDINATION OF COMMUNITY RESOURCES*	1. Document the rationale for interagency coordination and cooperation.	1. Describe the various agencies which are involved in coordinating services to children with the project. 2. Describe the various role and responsibilities of the agencies involved. 3. Document the formal and informal agreements which have been developed among agencies to provide comprehensive service to children. 4. Describe the activities which have taken place in on-going coordination. 5. Document the extent to which stated goals and objectives have been met.	1. Document the reaction of the community agency staff who have been involved in interagency coordination. 2. Document the reaction of the program staff who have been involved with coordination efforts.	1. Document the services which have been provided as a result of interagency coordination. 2. Document other changes which may have occurred as a result of the coordination of services.
DEMONSTRATION/ DISSEMINATION**	1. Document the rationale for demonstration/dissemination.	1. Specify the target audiences for each D/D activity. 2. Specify what project components or projects are to be demonstrated or disseminated. 3. Describe demonstration/dissemination activities. 4. Document the extent to which the goals and objectives of the D/D component were attained.	1. Document the reaction of D/D audiences as appropriate for specific activities.	1. Document change in knowledge or action of D/D audiences as appropriate for specific activities.

* Not included in the discussion presented by TADS, but included here because of its importance to program planning and evaluation.

** May not be a component of non-grant funded projects.

Table prepared from information presented in A Resource Book for Programs for Preschool Handicapped Children: Documentation, by T.M. Suarez and P. Vandiviere (Eds.), Chapel Hill, North Carolina: Technical Assistance Development System.

-What environmental conditions most facilitated growth?

-Was input from other agencies helpful?

-Do parents efforts at follow through make a difference in the rate of growth?

-and so on . . .

If just the accomplishment of the program objective is evaluated, much valuable information will not be obtained. Thus the variables and parameters related to each objective need to be studied to determine important interrelationships among inputs, processes and outputs which may have implications for program improvement.

The instruments used to gather evaluation data are extremely important. Use of poorly designed or inappropriate devises may yield inadequate data (at best) or even worthless data. The program evaluator needs an extensive background in tests and measurement. Whenever possible existing reputable instruments should be used. As in the case of individual child assessment, instruments should be

-valid

-reliable

-appropriate to the population

-practical (in administration and interpretation)

However, established instruments do not need to be utilized for every aspect of evaluation. Many instruments may need to be constructed to obtain information which is unique to the evaluation needs of the program. Questionnaires, rating scales, check lists, interview schedules, logs, anecdotal recording systems, inventories and observational systems are all frequently used tools in both formative and summative evaluation.

Analysis of data involves breaking down the information gathered into areas so that relationships can be seen between and among program variables.

Two types of data analysis are commonly utilized, logical analysis and statistical analysis (Renzulli, 1975).

Logical analysis involves taking descriptive data and looking for patterns trends and implications. Anecdotal records or information from open-ended questionnaires is often analyzed in this fashion.

Statistical analysis can be used to describe characteristics of groups in relation to particular variables. Means, standard deviations, medians, percentiles, stanines, are examples of statistical data which may be used to describe a population. Inferentaion statistics are then used to ascertain whether the differences between scores are significant. Tests of statistical significance include T - tests, analysis of variance and covariance, and multiple regression.

It is important that the evaluator have a working knowledge of the uses and limitations of such statistical devises, so as to plan appropriately for what information needs to be obtained. Statistical analysis is most useful in summative evaluation, and in trying to isolate variables which may be having an effect on certain outcomes. Again the audience should be kept in mind in presenting statistical data. This data may need to be described in lay terms, but supported by the statistical methodology.

In planning for both formative and summative evaluation, decisions need to be made around when data will be collected. It is wise to plan key formative evaluations early so that information obtained will be useful for making program improvements within that school year. Formative evaluations are done for the purpose of providing an on-going basis of decision-making concerning the services being provided to children and their families. By spacing evaluations carefully, knowledge gained may lead to important changes.

For example, if after the first quarter of the year: a) parents are surveyed to determine their level of satisfaction with program options; b) counts are made of parental involvement in program options; c) and data on parent follow-through is examined - factors may be identified which will allow for changes to be made to increase participation of both parents. The analysis of data may reveal the need for transportation, day care and evening and weekend options which may necessitate changing staffing patterns and service delivery options. If these checks aren't done early, the information will end up in summative evaluation - and thus changes will be made in the following year - with the possible consequence that children and families might not make as rapid progress as they would have had the changes been made earlier.

Who Evaluates

The question of who should do the evaluation is important as it is most desirable for the evaluator to be involved from the very beginning of program planning. In this way the evaluation can incorporate a comprehensive evaluation system suited to the objectives of the program, with appropriate formative measurement instruments ready to be operationalized from the beginning of the program.

The following section is offered as an example of how to plan for the summative evaluation of early childhood special education programs. The format used examines 1) evaluation questions, 2) the sources of data which might answer the question, 3) the method(s) to be used for data collection, 4) how data will be analyzed, and 5) when the information will be gathered. Each of the components is subdivided into areas of concentration.

I. Services to children
    A. Child Find
    B. Assessment
    C. Program
II. Services to families

    - A. Due process
    - B. Parent support
    - C. Parent involvement
    - D. Parent education

III. Staff development
    - A. Preservice/in-service
    - B. Staff evaluation

IV. Coordination of community resources

V. Demonstration/dissemination

The evaluation design is offered as a starting point for programs and is meant to provide examples of important concerns that deserve attention in planning for evaluation. Specific instruments are not recommended as these need to be selected according to individual needs of programs. The data gathered in this summative evaluation should provide information concerning overall program effectiveness as well as areas for program modification.

Formative Evaluation

The majority of evaluation concerns in the previous chart are summative in nature. They provide us with an overview of the strengths and weaknesses of the program. But perhaps even more essential is the evaluation data gathered by staff throughout the year. (Caldwell, 1977) state that formative evaluation can provide the data necessary to make decisions concerning daily practices which affect children and their families. Howell (1979) identifies the advantages of formative evaluation as:

1) allowing for more rapid detection of problems;
2) allowing a means for evaluating growth in children as it occurs;
3) providing the teacher with up-to-date feedback;
4) resulting in earlier changes in programs;
5) resulting in more rapid growth in children.

Perhaps the most important formative evaluation is that which measures the handicapped child's progress from day-to-day. There are many instruments available to provide growth information including criterion-referenced tests, teacher made task analyses, and precision teaching instruments. For additional information see Chapter 6 on Curriculum). The usefulness of these instruments is to facilitate observation of the child's progress. If progress is not occurring as rapidly as would be expected, then something is wrong and needs to be changed. On-going child assessment can raise the red flag for staff to look again at what is happening within the child's environment (or perhaps within the child in the case of a degenerative disorder).

There are, however, many other aspects of the program that are worthy of formative evaluation. Staff could improve their effectiveness if they would analyze the variables affecting various aspects of the program and determine the relationships among them. At the classroom level, there are many environmental parameters that affect the final behavioral results seen in the child, the parents and the staff.

Inputs	Outputs
Classroom environment:	Child behaviors
-Physical environment	Parents Behaviors
-Interpersonal environment	Staff Behaviors
-Curriculum	
-Schedule	
-Children	
-Parents	
-Staff	
-Therapies	

Under each of these areas, variables can be identified which will have an effect on the others and on the outputs. Harms (1979) identifies many of these variables. With some modifications these include:

Physical Environment
  - sound level
  - materials-number type developmental level
  - arrangement
  - availability of materials
  - variety of areas
  - displays
  - equipment

Interpersonal Environment
  - mutual respect
  - time spent with individual children
  - time spent with groups
  - time spent in directing children
  - handling of conflicts

Curriculum
  - range
  - developmental level
  - individual vs. group
  - child vs. teacher initiated
  - use of play

Schedule
  - time sequence
  - appropriate to age
  - appropriate to level
  - appropriate to handicap
  - variation in grouping
  - flexibility
  - time for parents

Other variables affecting outputs include:

Children

- -age range
- -handicap
- -severity
- -normal models

Parents

- -degree of acceptance of handicap
- -employment
- -flexibility of schedule
- -commitment
- -attitude

Staff

- -training and experience
- -role responsibilities
- -philosophy
- -commitment
- -flexibility
- -attitudes

Therapies/Specialized training

- -speech therapy
- -physical therapy
- -occupational therapy
- -psychotherapy
- -mobility training

It is extremely important that teachers understand that they make formative evaluation decisions almost every day. Any changes that are made in the child's environment or program are made after evaluating concerns relating to the aforementioned variables. Therefore, the outputs of child, parent and/or staff behaviors are strongly influenced by these evaluations decisions.

Staff should be encouraged to conduct mini "research" projects to determine how different variables can impact on the program to achieve more effective results.

Guidelines for Evaluation

1. The evaluation design should flow logically from the stated objectives of the program.
2. The evaluation design should be logical and consistent.
3. Measurements obtained should be appropriate to the stated needs and objectives.
4. Procedures for data collection should be carefully delineated (Bourgeois, 1971).
5. Both formative and summative evaluation measures should be incorporated from the beginning of the program.
6. With formative evaluation measures, systematic feedback mechanisms must be developed so that information reaches decision makers in time to make changes.
7. Decision makers at each level of decision-making responsibility must make a commitment to incorporate needed changes, based on evaluation data.
8. Information should be gathered on activities that can be modified.
9. Methods of data analysis should be outlined.
10. Avoid logical and statistical errors in design or interpretation by utilizing personnel or consultants who are knowledgeable in tests and measurements, or by utilizing established instruments.

I. Services to Children

A. Child Find

Evaluation Question	Source of Data	Data Collection Method	Data Analysis	When Gathered
Has joint planning taken place among agencies serving children and their families?	-Child Find Coordinator	Documentation of meeting, delineation of roles and responsibilities, formal and informal commitments.	Descriptive analysis	On-going plus summary annually
Have procedures been implemented to inform the community about: a. importance of early intervention b. availability of programs c. parent/child rights d. early warning signs	-Coordinator of Child Find activities	Documentation of newspaper articles, film clips, T.V., radio advertisements, meetings, brochures and their distribution	Descriptive analysis	Data collected in an on-going manner and summarized annually
How effective have the awareness efforts been?	-Parents in the community, -agencies serving family	Survey of parents by telephone, random questionnaire survey Survey of community agencies Summary data of number of referrals and source of referral	Descriptive and statistical analysis	Annually
Have procedures for locating all preschool children been implemented?	-Child Find Coordinator	Documentation of procedures	Analysis of percentage of population found	Documentation at the conclusion of activities
How effective are the location procedures	-Hospital birth rates -Kindergarten records -Screening results	Comparison of numbers of children screened with birth rate and school records	Descriptive plus percentage estimates	Annual
Is the identification/referral process effective	-Child Find Coordinator -Program Coordinator	Comparison of number of children referred with the number diagnosed	Statistical analysis	Annual

I. Services to Children:
B. Assessment

Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
Have procedures been established for conducting individual assessments?	-Program Coordinators	Documentation of procedures, numbers of children evaluated, types of instruments, staff, etc.	Descriptive	On-going data collection, summarized, yearly
Are assessment procedures in compliance with federal, state and local requirements?	-Program Coordinators	Comparison of procedures with federal, state, local guidelines	Descriptive	Annual
How effective are assessment procedures?	-Program Coordinators -Teachers -Parents	Interviews, questionnaires (post staffing) to determine if information was helpful. Comparison of assessment data to classroom	Descriptive	Intermittent (quarterly) checks
Have procedures for conducting a staffing been implemented?	-Program Coordinator	Documentation of procedures, who is involved, amount of time spent, records, etc.	Descriptive	Annual
Are staffing procedures in compliance with federal and state requirements?	-Program Coordinator	Comparison of procedures with federal and state guidelines	Descriptive	Annually

I. Services to Children B. Assessment Evaluation Questions	Source of Data	Date Collection Method	Date Analysis	When Gathered
How effective are the staffing procedures?	-Program Coordinator -Teachers -Parents	Interview or questionnaire distributed to participants of staffings. Tally the number of appeals Follow-up with teachers to ascertain if placement was appropriate.	Descriptive plus percentages	Collected throughout the year. Summarized annually
Are the I.E.P.'s developed for each child appropriate?	-Program Coordinator -Teachers -Parents	Survey of parents and teachers. Number of changes made after staffing.	Descriptive. How changes are necessitated. Satisfaction with I.E.P.s	Annual

I. Services to Children

C. Program Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
Has a full range of services been implemented?	- Program Coordinator	Documentation of range of options available, number of children participating in each option, staff allocations.	Descriptive	Annual
Is there evidence that the learning environment is maximally effective?	- Staff - Parents - Program Coordinator - Outside evaluator	Survey staff and parents through interview and questionnaire. On-site review by coordinator or expert using observation guide.	Descriptive data from observation tools. Descriptive data summarizing surveys.	As needed when questions arise. Once mid year and end of year.
Are the methods and activities used by staff maximally effective in achieving children's goals and objectives?	- Staff	Test of performance of child based on CRT and norm-referenced instrument.	Descriptive and statistical analysis	Ongoing and summary of performance at year end
Is there evidence that the content and sequence of the curriculum is developmentally appropriate?	- Staff	Child progress and documentation that the curriculum is sequential and based on learning theory.	Descriptive	Beginning of program revised as needed.
Have procedures for ordering equipment been developed which require justification that materials are developmentally appropriate and geared to the needs of handicapped children?	- Program Coordinator	Documentation of procedures inventories, forms; when used, etc.	Descriptive	Prior to beginning program, and end of year.

I. Services-to Children C. Program Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
How effective are the materials and equipment used in the program?	-Staff	Frequency-of-use survey with inventory check.	Descriptive	Annually
Is there evidence that the instructional groupings are based on need rather than disabilities?	-Program Coordinator	Child progress and documentation of procedures for determining groupings; policy statement.	Descriptive	At beginning of the program
Is there evidence that the staff utilization model is transdiciplinary?	-Program Director -Staff	Job descriptions, staff assignments, time-activity records, staff log.	Descriptive	Annually
Is there evidence that the staff/child ration is optimal?	-Program Director -Staff -Parents	Time/work sheets; survey of staff, parents.	Descriptive	Annually
Does the staff possess necessary skills to intervene in all necessary aspects of the child's program?	-Program Coordinator	Staff evaluation through output and interview	Descriptive	On-going but at least annually
Do teachers, administrators, support personnel and parents have a positive attitude about the program?	-Administrators -Staff -Parents	Survey of these groups through interview and/or questionnaire	Statistical analysis of results.	Annually or every two years.
Is there evidence that the overall program is making a significant difference in children's learning?	-Staff -Assessment team	Group progress on standardized instruments. Group tally of numbers of objectives attained.	Pre-test/post-test design, statistical analysis	Annually

I. Services to Children
C. Program

Evaluation Question	Source of Data	Data Collection Method	Data Analysis	When Gathered
Have procedures for the smooth transition from one program to another be implemented?	-Program Coordinator	Documentation of procedures, forms, flow-charts, meetings, etc.	Descriptive	Every two years
Are the transition procedures effective?	-Staff -Teachers	Attitude survey. Follow-up of child progress via I.E.P.	Descriptive	Every two years
Have procedures for integration with nonhandicapped children been implemented?	-Program Coordinator	Documentation of procedures, number of handicapped and nonhandicapped integrated, participating, length or frequency of contact, nature of interaction.	Descriptive	Every two years

II. Services to Parents

A. Due Process

Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
Is information on due process procedures made available to parents prior to assessment and staffing?	-Program Coordinator	Documentation of information given to parents delineating their rights.	Descriptive	Beginning of the year: This information should be made available to parents upon referral for evaluation.
Is there evidence that parents understand their rights?	-Parents -Program Coordinator	Survey by interview, questionnaire. Document number of parents who appeal staffing decision.	Descriptive	Annually
Are parents actively involved in staffings and the development of I.E.P.'s?	-Parents -Program Coordinator -Staff	Documentation of parental input into I.E.P. Survey of staff to determine parents' attitude after staffing their child.	Descriptive	Annually
Are there procedures for informing parents of their child's progress.	-Program Coordinator	Documentation of scheduling and procedures for parent-staff counseling meetings.	Descriptive	Annually
Is there evidence that parents understand the method of measuring the progress.	-Parents	Survey parents by interview and questionnaire.	Descriptive	Annually

II. Services to Parents B. Parent Support Evaluation Question	Source of Data	Data Collection Method	Data Analysis	When Gathered
Are options available for parents to obtain support and counseling?	-Program Coordinator	Documentation of nature of services availabe to parents, number of parents served in each.	Descriptive Analysis	Annually
Are parent support and counseling effort effective?	-Parents	Attitude of parents measured through interviews, questionnaires or rating scales.	Descriptive Analysis	Intermittent
C. Parent Involvement				
Are options available for parent participation?	-Program Coordinator	Documentation of options available, number of parents participating.	Descriptive	Annually
Are parents involved in decisions making, program planning and operation?	-Program Coordinator	Documentation of the types of decision-making activities, number of parents involved.	Descriptive	Annually
Is there evidence that parent participation is meaningful to the parents?	-Program Coordinator	Survey of parents to determine their perception of their participatory role.	Descriptive	Annually

II. Service to Parents

D. Parent Education

Evaluation Question	Source of Data	Data Collection Method	Data Analysis	When Gathered
Are options available to parents for obtaining information concerning issues related to their handicapped child?	-Program Coordinator -Staff -Parents	Document options available -Classes -Workshops -Library -Video Tapes -Counseling sessions -etc.	Descriptive	Annually
Is there evidence that parents have increased their knowledge about issues related to their handicapped child?	-Program Coordinator -Staff -Parents	Document numbers of parents utilizing each option -pre/post test in courses and workshops. -questionnaire, ratings	Descriptive and percentage analysis	On-going analysis, evaluate each class or workshop at the time of presentation. Year-end summary of total effectiveness
Are the parents given opportunities to increase their skills in working and playing with their handicapped children.	-Staff	Documentation of processes used to teach parents intervention skills and outcomes.	Descriptive	Annual
Is there evidence that parents are effectively interacting with their children and providing a stimulating environment for growth?	-Staff -Parents	Document numbers of programs planned and/or completed by parents, types of changes made in home environments, pre/post. Survey of parents by interview and questionnaire to determine their comfort level in interacting and working with their handicapped child.	Descriptive and Statistical Analysis	Annual

III. Staff Development

A. Pre-service/Inservice Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
Have role descriptions been written delineating responsiblities, background and experience desired?	-Program Coordinator	Documentation of job descriptions	Descriptive	Prior to hiring program staff
Have persons been hired with philosophy and skills needed in the program?	-Program Coordinator	Documentation of criteria for selection of staff, job applicants	Descriptive	Annually
Has a needs assessment been implemented to determine training needs prior to (if possible) or after program initiation?	-Program Coordinator	Documentation of needs assessment procedures, who was surveyed, when, how, with what results?	Descriptive	Beginning of year and ongoing
Have systematic procedures for inservice training been implemented?	-Program Coordinator	Decumentation of procedures, i.e., identitication of objectives, format, dates, attendance, etc.	Descriptive	Ongoing
How effective are the procedures for inservice training?	-Staff involved in training	Evaluation questionnaire on content, organization, presentation, etc. given to participants of training.	Descriptive and Statistical Analysis	Ongoing with annual summarization.
Have the client groups acquired the awareness, knowledge or skills targeted in training?	-Program Coordinator -Staff	-On-site observation of skills, development of product or pre/post test.	Descriptive and Statistical Analysis	Ongoing, plus annually

III. Staff Development

B. Staff Evaluations

Evaluation Questions	Source of Data	Data Colleciton Method	Data Anaysis	When Gathered
Are there procedures for evaluation of individual staff members?	-Program Coordinator	Documentaion of procedures, forms, interviews, observation scales.	Descriptive	Prior to beginning of the year
Are the procedures for staff evaluation effective and acceptable to staff?	-Program Coordinator -Staff	Documentation of results of evaluation, staff development, reassignment, etc. Survey of staff attitude toward evaluation procedures.	Descriptive	Annually or every two years
Are there procedures for determining effectiveness of staff utilization?	-Program Coordinator	Documentation of time scheduling, staff/child ratios, meeting times, planning time, etc.	Descriptive	Annually
Are the staff utilization procedures effective?	-Program Coordinator -Staff	Survey of staff	Descriptive	Annually

IV. Coordination of Resources Evaluation Questions	Sources of Data	Data Collection Method	Data Analysis	When Gathered
Has a system for coordinating contacts between various public and private agencies been implemented?	-Program Coordinator	Document interagency network development - logs, matrices, diagram of interrelationships.	Descriptive	Prior to initiation of program.
Have procedures been established for coordinating services to children and their families?	-Program Coordinator	Document procedures for coordination of services, i.e., services summary, duplication and gaps, formal and informal agreements, objectives, responsibilities.	Descriptive	Prior to initiation of program Ongoing as needed for specific children.
Are the interagency coordination efforts effective?	-Program Coordinator -Other agencies	Survey of representatives of cooperating agencies to ascertain degree of satisfaction with cooperative efforts. Document number of children and/or families receiving cooperative services and/or funding.	Descriptive	Ongoing and Annually

V. - Demonstration/Dissemination Evaluation Questions	Source of Data	Data Collection Method	Data Analysis	When Gathered
Have materials, strategies, products to be demonstrated or disseminated been identified?	-Program Coordinator	Documentation of objectives of demonstration and dissemination.	Descriptive	Beginning of Program
Have procedures and timelines for the development of materials, products, strategies, etc. been developed?	-Program Coordinator -Staff	Documentation of plans, time lines, outlines, etc. related to each D/D project.	Descriptive	Beginning of Program
Have a variety of demonstration/dissemination efforts been implemented?	-Program Coordinator	Documentation of speeches, workshops, presentations, articles, publications, final products, etc.; with dates, audiences, and presentor	Descriptive	On-going
Have demonstration/dissemination efforts been effective?	-Program Coodinator -Staff	Evaluation questionnaires after presentations Document change in knowledge of audiences Number of publications Number of replication sites and number of children served.	Descriptive and appropriate statistical analysis.	On-going

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GLOSSARY

GLOSSARY

Apgar Score. A score of from one to ten on a scale measuring vital signs of a newborn baby at one and five minutes after birth. Devised by Virginia Apgar, M.D.

Central Nervous System. Part of the total nervous system. It includes the brain and the spinal cord. Sensory impulses are transmitted and motor impulses pass out.

Cerebral Palsy. Any of a group of conditions affecting control of the motor system due to lesions in various parts of the brain.

Cognitive. The faculty of knowing, or becoming aware of objects of thought or perception, including understanding and reasoning.

Compensatory. To compensate for educational deprivation. Primarily for provision of instructional activities to educationally deprived children in areas having a high concentration of children from low-income families.

Comprehensive Individual Planning. Planning for all aspects of the child's life. An ecological approach to intervention.

Criterion Referenced Tests. Level of achievement is determined by the content of the test. The child is compared to a set of standards, not other children.

Cueing. A short auditory or visual direction given to initiate a behavior.

Deaf/Blind. A combined vision-hearing handicap to the extent that they cannot benefit from instruction in a program for either visually handicapped or hearing handicapped.

Due Process. A series of steps which assures the right of the parent and child to be fully informed and to be included in decision-making at all steps in identification, child evaluation, planning, programming and program evaluation. The purpose of due process is to ensure equal protection under the law.

Equilibrium Reactions. Highest level of reactions. Helps body stay in position after righting reactions, also referred to as tilting reactions.

Expressive Language. The ability to express or communicate verbal, written or symbolic language.

Fine Motor. Activities or outputs in which precision in delicate muscle systems is required, primarily related to movements of fingers and hands.

Gross Motor. Activities or outputs in which groups of large muscles are used and the factors of rhythm and balance are primary.

Hearing Handicapped. A deficiency in hearing acuity, as demonstrated by the reduced threshold of auditory sensitivity to pure tones or speech, sufficient to affect the ability to communicate with others where even with the help of amplification, the child requires supplementary assistance or modification of instructional methods and materials in order to communicate, function and learn.

Intervention. The provision of materials and/or services to a handicapped child and his/her family in order to facilitate growth and development.

Mobility Training. Instruction in moving through space and awareness of environment using tactile and auditory cues.

Modeling. Showing or demonstrating to others how to perform particular behaviors. Can also cause learning through observation of incidental behaviors.

Multiple Handicap. Refers to any combination of the following handicaps that is severe enough in nature or in total impact to affect significantly the student's ability to function and learn: vision, hearing, significant limited intellectual capacity, emotional/behavioral, perceptual/communicative, and physical impairment.

Neuromotor Development. Concerned with the maturation of the nervous system and the parallel acquisition of control over the muscular system.

Prompting. The process of giving a child a specific cue to initiate a behavior. Such prompts may be verbal, visual, physical, auditory or written.

Norm Referenced Test. Level of achievement is determined by the norms of the sample or population of persons on which the test was standardized.

Over Identification. Also known as false positive. Referring children for evaluation who do not have a handicap.

Perceptual/Communicative Handicap. (or Learning Disabled) Indicated when there is a significant discrepancy between estimated intellectual potential and actual level of performance and is related to basic disorders in the learning processes which are not secondary to limited intellectual capacity, visual or auditory sensory impairment, emotional disorders, and/or experiential information.

Perseverate. Inappropriate and purposeless repetition of a past experience (body rocking, repeating a word over and over again, waving arms endlessly.)

Phyical Handicap. An impaired ability to participate in the regularly provided school program because of medical, orthopedic, neurological and/or sustained illness or crippling conditions.

Preventive Services. Services to preclude occurrence of or deterioration of handicapping conditions or family problems (e.g. genetic counseling, parent education)

Protective Reactions. Reactions in the limbs to sudden displacements of the erect trunk.

Receptive Language. The ability to understand spoken, written and symbolic language.

Reflex. Involuntary response to a stimulus.

Reliability. A test is reliable when it provides the same estimate of behavioral performance in a consistent manner.

Respite Care. Provision of short term residential care to a handicapped child to allow the family time to themselves.

Righting Reaction.

(a) Head righting: the righting of the head in space

(b) Sagittal trunk righting: the extension of the spine in the sagittal (long axis of the body) plane with extension of the hips when the infant is suspended in the prone position.

(c) Derotative righting: this reaction is an untwisting when rotation is applied along the body axis.

Sensorimotor Integration. Organization of many types of sensations by the central and peripheral nervous systems which allows the child to move and function effectively in his/her world.

Shaping. A basic process of operant conditioning involving the reinforcement of successively closer approximations to the desired behavior.

Significant Identifiable Emotional or Behavioral Handicap. Refers to social or behavioral functioning such that the child cannot be adequately and/or safely educated in the regular school program.

Significant Limited Intellectual Capacity or Mental Retardation. A handicap manifest by a reduced general intellectual functioning, usually originating in the developmental period and associated with impairment in adaptive behavior.

Speech Handicap. A speech deficiency which interferes with communication, or causes undesirable or inappropriate behavior.

Standardization. The norms (performance or demographic characteristics) of the individuals for which the test was developed and with whom the test was validated.

Validity. Exists when the test has been proven to measure what it purports to measure. A test is validated when a high correlation exists between its results and those of a test measuring similar behaviors.

Vision Handicap. A deficiency in visual acuity where, even with the use of lenses or corrective devices, the child requires modification or adaptation of instructional methods and materials or supplementary assistance in order to function and learn.

Volitional Movement. Motor functions controlled by the child.

APPENDICES

Appendix

A

Funding Sources

PUBLIC
FUNDING ALTERNATIVES
STATE ADMINISTERED PROGRAMS

by BRIAN A. MCNULTY

From Public and Private Funding Alternatives (6) by Brian A. McNulty and Arthur J. Moreau, distributed by the Western States Technical Assistance Resources, Seattle, Washington, April, 1980.

Public Law 94-142, which is a revision of Part B of the Education of the Handicapped Act, revised the federal funding formula and ceiling, as well as increased many programmatic requirements. The monies received by states are based on a per pupil count submitted to the federal government, but are contingent on the approval of the state's Annual Program Plan. Presently the national allocation is in excess of $800 million. Based on the national per pupil count, this money is distributed proportionately, or on a prorata basis, to states. Seventy-five percent of these funds flow directly to local school districts and 25 percent are retained at the state level. Of the latter portion, 5 percent may be used for administration and 20 percent for state-directed activities (such as inservice, materials development, model programs, or state child find activities). Although these funds are being used differently in each state, this 20 percent share ($160 million) constitutes a major funding source worth exploring. Contact should be made with your State Education Agency (SEA) Special Education Office, special education director, or federal programs director regarding the present and future utilization of these funds. You may also want to work with your State Special Education Advisory Board in setting up priorities for the use of these funds. As mentioned above, there are very few limitations on how these funds can be spent except that they must address the priorities of P.L. 94-142 (i.e., the unserved and then the underserved). Preschool handicapped children may be considered unserved or underserved depending on your state law or state plan application. All children within the state's mandated ages (e.g., birth to 21, 3 to 21, 5 to 21) who are not being served must be considered "first priority" to receive services. Even if not mandated, you may include preschool handicapped children as unserved or underserved in your state plan application, but at the discretion of the state.

One additional requirement for state and local school districts is the identification, location and evaluation of all handicapped children, including the birth to 5-year-old handicapped child. Since many states and local districts do not have the capacity or trained staff to accomplish this requirement, projects may want to explore how this might be accomplished through cooperative ventures with the local school district, such as joint funding, staffing, or other means.

While indirectly discussed above, Local Education Agencies (LEA's) receive their 75 percent allocation from P.L. 94-142 based on the number of handicapped children in their jurisdiction ages 3 to 21 years who are receiving special education and related services. This includes all handicapped children ages 3 to 21 years who are identified and reported by the LEA as handicapped and receiving a free and appropriate public education, including related services. Free appropriate public education means special education and related services which are provided at public expense, with out charge, meet state standards, and are in conformity with the requirements for an individualized educational program (IEP). This count may include children currently being served in local programs not operated by the public schools. For example, if a preschool child (ages 3 to 5) is identified as handicapped and receiving a free appropriate public education, he may be counted by the LEA and therefore generate P.L. 94-142 funds. These funds would then flow directly to the LEA to be used as outlined in their local application. Local programs could receive these funds if they met the requirements listed above for a free appropriate public education. These children would however, have to be counted and reported in order to generate such funds. To explore this option you should contact your local special education director or your state Part B (P.L. 94-142) coordinator.

PRESCHOOL INCENTIVE GRANTS

A second state-administered discretionary grant program is the Preschool Incentive Grants. Under P.L. 94-142, Section 619, states are eligible for additional funding based on the number of handicapped preschool children ages 3 to 5 that are served. Again, the SEA must submit an application, which must be approved, along with the Annual Program Plan. The funds are used to meet "the educational needs of handicapped children ages 3, 4 and 5" (Section 121M.5 Rules and Regulations P.L. 94-142). Since these funds may be used for such activities as model projects and inservice programs, local projects may want to contact their SEA's to explore how these funds are being used and to assist in planning and implementing these grants. Several states have developed consortia composed of First Chance projects to help their states implement this program. Presently, the Preschool Incentive Grant program is funded at over $15 million nationally.

ESEA TITLE I Since the mid-60's, the major program for educational aid has been Title I of the Elementary and Secondary Education Act (ESEA). This formula grant program includes four specific target groups: (1) educationally disadvantaged, (2) migrant, (3) neglected and delinquent, and (4) handicapped.

EDUCATIONALLY DISADVANTAGED. The Basic Grant Program, the largest of the Title I programs, is based on the statewide total of eligible children. While primarily directed at the educationally disadvantaged child (grades K-12), Basic Grant Programs can be used to fund early education programs for "educationally disadvantaged" preschool children. These funds only go to qualifying Title I school districts. The decision on how to use these funds is a local school district's option. Programs affiliated with local school districts may want to explore this option with their local Title I coordinator.

MIGRANT. The migrant program under Title I provides supplemental educational services to children of migratory agricultural workers and fishermen. Eligible migratory children are those (birth through 5) who have moved within the past 12 months with a parent or guardian in order to secure temporary or seasonal employment in agricultural or fishing activities. This eligibility continues for up to five years after the family has ceased to migrate. Local school districts operate these programs, and they may be contacted for specific details on services. For general information as to the numbers and ages of migrant children being served in your own state, contact your State Department of Education, Migrant Education Program Director, or your state Migrant Council.

NEGLECTED AND DELINQUENT. The programs for neglected and delinquent children provide support for supplemental educational programs in state institutions. Since this program has little applicability for preschool handicapped children, it will not be discussed in further detail.

HANDICAPPED. Briefly mentioned in the introduction was the handicapped component of Title I ESEA (P.L. 89-10 as amended by P.L. 89-313 and P.L. 93-380). Under this program, funds are available to extend and improve comprehensive educational programs for handicapped children who are, or have been, enrolled in state operated or supported schools. As with P. L. 94-142, grants are awarded to states based on a per pupil count. However, the Title I funds follow the child, meaning that children who are or were enrolled for at least 180 days in a state operated or supported school are eligible. State operated schools may include state institutions and, in some cases, state supported but locally operated programs, such as developmental disabilities (DD) centers. Since monies (over $600 per child) follow the child, children who are or were enrolled in such programs continue to be eligible indefinitely. Local programs should explore whether they are a state operated program and/or whether children they are serving have ever been in a state supported program and therefore eligible for Title I (89-313) funds. Since funding is based on a per pupil count, local projects should check with their state Title I (89-313) coordinator to insure that eligible children are counted and to insure their receipt of these monies.

BILINGUAL Depending on state definitions and age requirements, projects associated with local school districts may be eligible for state or federal bilingual funding. In addition, some funds have also been available under Title VII of the ESEA Bilingual Education Act for bilingual education classrooms and demonstration projects. For additional information on this program contact the Office of Bilingual Education, USOE, 400 Maryland Avenue, S.W., Washington, D.C. 20202.

TITLE XX Another indirect source of funds is Title XX training grants. Under Section 504 of the Rehabilitation Act of 1973, preschool and day care programs receiving federal funds have some obligations to integrate handicapped preschool children. Although the requirements are somewhat vague and State Departments of Social Services or Human Resources may not be fully aware of this legislation, it may prove fruitful to explore this area in terms of Title XX training grant monies. While more recently Title XX training grants have been curtailed at the state level, it appears that training in the integration of young handicapped children is not only timely but mandated by this statute. For additional information, contact your State Title XX Office in your State Department of Social Services or State Department of Human Resources.

LOCALLY ADMINISTERED PROGRAMS

TITLE XX In addition to the training monies discussed in the previous section, other Title XX funds are distributed to states on a formula basis according to population. While states submit Annual Comprehensive Plans, most of these monies flow to local Departments of Social Services or Human Resources. Depending on income eligibility and other requirements, children in your programs may be eligible for Title XX funds. Usually states have differential rates for preschools and day care and for children who are handicapped. Programs may also want to participate in the Title XX planning process at the local and state levels to insure inclusion of services for young handicapped children.

EPSDT

Four other programs which may assist local programs are EPSDT, SSI, WIN, and the Maternal and Child Health's Crippled Children's Program. The Early Periodic Screening Diagnosis and Treatment (EPSDT) program is the child health, screening, diagnosis and treatment component of the Medicaid program. It provides health and treatment coverage to eligible low income and medically needy persons under the age of 21. Any person eligible for Medicaid is also eligible for EPSDT. The EPSDT program can assist a local project in several ways. It can supplement services already being provided, resulting in a more comprehensive program. A more difficult, but more profitable, option is for your program to be designated as a Medicaid vendor. As a vendor you are eligible to charge the federal government (Medicaid Bureau MMB, Health Care Financing Administration of HEW) for certain services provided to Medicaid children. These services can include speech, physical and occupational therapies, prosthetic devices, and dental care. Medicaid vendor licenses are provided by the state. Contact your appropriate state agency regarding eligibility. The proposed Child Health Assurance Program (CHAP), currently in Congress, is a revision of the EPSDT program. If passed, it will in all likelihood expand the scope and funding of the program.

SSI

Low income families may also be eligible for the Supplemental Security Income (SSI) Program. SSI is an income maintenance program which provides monthly income to aged, blind and disabled persons, including children under age 16. This program can pay for treatment services. Since eligibility requirements vary, check with your local social security district or branch office for more information.

WIN

The Work Incentive Program (WIN) can purchase services such as preschool and day care for eligible recipients (usually families on Aide to Families with Dependent Children, AFDC). The program is most often administered through state and local Departments of Social Services or Human Resources.

MATERIAL AND CHILD HEALTH

Under Title V of the Social Securities Act/Maternal and Child Health Programs, states receive formula grants based on certain populations of children and rural factors. These funds are divided into two categories:

A funds, which require matching state and federal dollars.

B funds, which require no matching monies.

While the ratio of this funding varies from state to state, usually part A funds are used for defined activities and populations such as child health clinics and crippled children's programs. Part B funds are used in a more discretionary manner for preventive and educational activities. To explore the availability of these funds, contact the local or state Public Health Office, Maternal and Child Health Division.

SUMMARY

Given the myriad of potential funding sources available, some of those with the greatest applicability for programs serving young handicapped children were discussed in this section. For each of the programs discussed, the eligible population and local or state contact person were identified. Exploring multiple sources of funds, considering the population of children served, will help to create a more stable, diverse funding base for early childhood special education programs. Additional sources of information related to public monies may be in the bibliography.

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A basic and complete source of information on federal grant programs. Provices name of programs and administrative departments, kinds of projects funded, guidelines and regulations, application procedures, information contacts, etc. A good starting point for exploring federal programs.

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Focused primarily at large institutions, has valuable information for smaller, nonprofit agencies regarding the practice of federal grantsmanship.

Dodge, A. B. How to raise money for kids (public and private). Washington, D.C.: Coalition for Children and Youth, 1978. Available from CCY, 815 15th Street N.W., Washington, D.C. 20005 ($2.00).

Organized in three sections: (1) concrete tips for preparing and necessary components of proposals, with examples; (2) locating and pursuing foundation monies; (3) background information of the federal grant process and a helpful analysis of the Catalog of Federal Domestic Assistance Programs. Written for lay persons; is a good practical resource with many examples.

Eckstein, B. J. (Ed.). Handicapped funding directory: 1980-81 edition. Oceanside, New York: Research Grant Guides, 1980. Available from Research Grant Guides, P.O. Box 357, Oceanside, New York 11572.

Lists foundations, associations, and federal agencies which have funded programs and services for the handicapped. Includes an essay on writing a successful proposal. Names and addresses are provided for pursuing appropriate funding, along with information on eligibility, sponsor's objectives, application process, and range and average of assistance.

Foundation Center national data book, a publication of the Foundation Center, 888 Seventh Avenue, New York, New York 10019. Order from that address.

Contains information on all foundations classified by the IRS. Indexed by state in descending order of size of grants. Gives foundation

name, address, principal officer, assets, amount of grants made within the most recent year. Includes even the smaller foundations in each state.

Foundation directory, a publication of the Foundation Center, 888 Seventh Avenue, New York, New York, 10019. Available from Columbia University Press, 136th So. Broadway, Irvington, New York 10533.

Contains information on the largest U.S. foundations, accounting for about 80 percent of foundation grants each year: application procedures, phone numbers, etc. Cross indexed by subject (within general areas such as education), state and city, foundation name, and others.

Foundation grants index, a publication of the Foundation Center, 888 Seventh Avenue, New York, New York 10019. Available from Columbia University Press, 136 So. Broadway, Irvington, New York 10533.

Covers major U.S. foundations with detailed summaries of thousands of awarded grants.

Gilkerson, L., & Trohanis, P. *Resources for early education programs for children with handicaps*. Chapel Hill, North Carolina: Technical Assistance Development System, 1977. Available from ERIC Document Reproduction Center, P.O. Box 190, Arlington, Virginia 22210. (Document number ED 150 815, paper copy $2.06).

Contains information on (1) sources of funding available for services to young handicapped children, (2) sources of training for personnel, and (3) agencies and organizations who are information resources.

Levine, J. *Hustling resources for day care*, and *Supplement and revisions to hustling resources for day care*. Available from Day Care Child Development Council of America, 1012 14th Street N.W., Washington, D.C. 20005.

"How to" suggestions for writing proposals and finding funds for children's services, plus a bibliography.

Moss, J. W. Finding money for developing replicable products. In L. Gunn (Ed.), *Outreach: Replicating services for young handicapped children*. Chapel Hill, North Carolina: Technical Assistance Development System, 1975.

Discusses the problems and necessary considerations of finding continuation funds for service delivery. Presents advice on where and how to look for monies.

Free or inexpensive information on foundations. Available from the Foundation Center, 888 Seventh Avenue, New York, New York 10010.

Jacquette, L., & Jacquette, B. *What makes a good proposal?*, 1973. (10¢) Meyer, R.A. *What will a foundation look for when you submit a grant proposal?*, 1972. (10¢).

Andrews, F. W. Philanthropy in the United States: History and structure. (50¢) Personal contact -- Is it really necessary? (free). Margolis, J. B. About foundations. How to find the facts you need to get a grant, 1977. ($3.00).

Appendix

B

Examples of Evaluation Forms

Evaluation of Interagency Cooperation

The following form will be used to help us assess the effectiveness of our cooperative efforts.

1. Overall, I would say the cooperative efforts among agencies in our district has been (circle one)

1	2	3	4	5
Virtually Non-existant	Not Very Good	Average	A Substantial Effort Has Been Made	Good Cooperation and Coordination Exists

2. Rank (1=low, 5-high) how you perceive the efficacy of various aspects of interagency efforts.

	Low				High
--increased communication	1	2	3	4	5
--increased knowledge of available community resources	1	2	3	4	5
--increased flexibility in providing services	1	2	3	4	5
--more services available	1	2	3	4	5
--elimination of gaps in services	1	2	3	4	5
--reduction of duplication of services	1	2	3	4	5
--more effective use of personnel and resources	1	2	3	4	5
--better long range planning	1	2	3	4	5
--other: list					

3. Barriers which continue to exist include (check those which are appropriate):

__insufficient money to pay for needed services

__insufficient staff to provide comprehensive service

__insufficient materials and equipment

__lack of appropriate facilities

__lack of responsiveness from community resources

__hesitancy on the part of staff to coordinate services

__lack of time to work in coordination

__lack of knowledge about how to go about the coordination

__lack of parent cooperation

__lack of facilitative legislation

__prohibition by regulations

__unavailability of qualified staff

4. How could interagency cooperation be improved?

APPENDIX F-17

I.E.P. - IMPLEMENTATION PLAN (Elementary Level)

PART D

Student: School: Date:

GOAL (statement of desired educational performance to be achieved at end of school year)

SPECIAL MATERIALS/EQUIPMENT TO BE USED

SPECIAL STRATEGIES/ACTIVITIES TO BE IMPLEMENTED

SPECIFIC PERFORMANCE/BEHAVIOR OBJECTIVES (measurable steps toward attainment of goals)

OBJECTIVE	Criteria/Procedure for Determining Attainment	Date Attained

NOTES/COMMENTS

EVALUATION OF GOAL ATTAINMENT

Evaluator: Date:

ORIGINAL - Diagnostic Folder Copies - Central Folder, Parent

Additional Copies to

APPENDIX F-19

I.E.P. - END-OF-YEAR STATUS

PART E

STUDENT	SCHOOL	DATE

_____ Transferred out of special education - objectives accomplished. Date: ____________________

_____ Transferred out of district to ____________________

_____ Retained for next year in special ed. Location: ____________________

_____ Withdrawn from special education. Reason: ____________________

_____ Discontinued from school. Reason: ____________________

_____ Graduated from school.

_____ Other: ____________________

TOTAL NUMBER WEEKS IN PROGRAM: __________ TOTAL HOURS SERVED: __________.

SUMMARY OF PROGRESS TOWARD I.E.P. GOALS (SEE PART B):

Original: Diagnostic Folder Copies: Central Folder Parent

209570

APPENDIX F-20

CONSIDERATIONS FOR NEEDS ASSESSMENT:

CURRICULAR NEEDS
- method of presentation
- level of materials
- type of equipment

PHYSICAL ENVIRONMENT NEEDS
- work area for equipment
- special storage
- visual stimulation
- noise level
- lighting

TEACHER/STUDENT INTERACTION NEEDS
- amount of structure
- number in group
- level of activity
- behavior management
- adaptive teaching

SOCIAL/EMOTIONAL NEEDS
- motivational structure
- peer relationships
- self-concept
- acceptance of handicap

TRAINING NEEDS
- special physical education
- motor skills
- handwriting
- typing
- Braille reading
- use of low visions aids
- orientation & mobility
- use of residual vision
- use of residual hearing
- speech reading
- alternate communication
- attending skills
- organizational skills
- perceptual skills
- listening skills
- memory
- speech articulation
- speech fluency
- voice
- receptive language
- expressive language
- written expression
- concept development
- use-subj. area aids
- daily living skills

AVOCATIONAL/PREVOCATIONAL/VOCATIONAL NEEDS
- recreation/leisure time
- econ./career awareness
- occupational goals
- employability skills
- specific voc. skills

HOME/SCHOOL INTERACTION NEEDS
- consistency
- reinforcement
- communication

TRANSPORTATION NEEDS
- special bussing
- special equipment
- special instructions

SERVICE DELIVERY ALTERNATIVES:

CONSULTATION - special educator consults to regular education teachers, monitors student's progress, counsels student, confers with parents, assists with materials, equipment.

ITINERANT - consultation, special training, and supplemental instruction to enable the student to attain regular education objectives; typically 1-6 hrs/wk.

RESOURCE - itinerant services plus special education responsibility (instruction) for at least one of the following areas: language arts, mathematics, science, social studies.

SELF-CONTAINED - special education responsible for subject area instruction and special training; P.E., Fine Arts, Practical Arts may be provided through regular ed. programs.

HOME/HOSPITAL - any of the above services at home or while hospitalized.

WORK-EXPERIENCE-STUDY - specialized vocational training and supervision beyond the capability of available vocational programs; (combined with another delivery).

I.E.P. - END-OF-YEAR STATUS

PART E

STUDENT	SCHOOL	DATE

____ Transferred out of special education - objectives accomplished. Date: ____________

____ Transferred out of district to ____________

____ Retained for next year in special ed. Location: ____________

____ Withdrawn from special education. Reason: ____________

____ Discontinued from school. Reason: ____________

____ Graduated from school.

____ Other: ____________

TOTAL NUMBER WEEKS IN PROGRAM: ____________ TOTAL HOURS SERVED: ____________.

SUMMARY OF PROGRESS TOWARD I.E.P. GOALS (SEE PART B):

Original: Diagnostic Folder Copies: Central Folder, Parent

PROGRAM EVALUATION FORM

Date: ______________________________ Age of Child: ______________________________

On the rating scale below, circle the number which most accurately reflects your opinion. Feel free to add comments.

1. What is your overall attitude toward your child's program?

1	2	3	4	5
Very Negative		Neutral		Very Positive

Comments:

2. How well do you think the program meets your child's needs?

1	2	3	4	5
Meets no needs		Meets some		Meets all needs

Comments:

3. How well do you feel the program meets your family's needs?

1	2	3	4	5
Not at all		Moderately		Very Well

Comments:

4. In working with staff from the school, do you feel that your opinions are sought and count in decision-making?

1	2	3	4	5
Never		Sometimes		Always

Comments:

5. When you express a need or concern to a staff member do you feel there is some action taken?

1	2	3	4	5
Never		Sometimes		Always

Comments:

6. Do you feel that the staff has encouraged your family's involvement in the program?

1	2	3	4	5
Never		Sometimes		Always

Comments:

7. Do you feel that you have been given sufficient suggestions for how to help your child learn at home?

1	2	3	4	5
Not Enough	Fairly Adequate	Adequate	Very Adequate	Too Much

Comments:

8. Do you feel the team has been able to work effectively with your child?

1	2	3	4	5
Not Effective		Adequate		Very Effective

Comments:

9. How do you feel about your play interactions with your child?

1	2	3	4	5
Very Difficult	Uncomfortable	Adequate	Positive	Very Positive

Comments:

10. Do you feel staff members have adequately interpreted your child's strengths and weaknesses?

1	2	3	4	5
Not at all	Not well	Fairly well	Very well	Excellent

Comments:

11. Do you feel that team members have helped you to better understand your child's weaknesses?

1	2	3	4	5
No help provided		Adequate help		Very helpful

Comments:

12. Do you feel that team members have helped you to better understand your child's strengths?

1	2	3	4	5
No help provided		Adequate help		Very Helpful

Comments:

13. Do you feel there is adequate communication between home and school?

1	2	3	4	5
No Communication		Adequate		Excellent Communication

Comments:

14. Do you feel the school has adequately informed you of your rights?

1	2	3	4	5
No information		Some information		Comprehensive Information

Comments:

15. Has transportation been adequate?

1	2	3	4	5
Constant Problems	Many Problems	Some Problems	Very Few Problems	No Problems

Comments:

16. How would you describe your child's relationship with staff?

1	2	3	4	5
Very Poor	Fair	Good	Very Good	Excellent

Comments:

17. How would you describe your relationship with staff?

1	2	3	4	5
Very Tense	Somewhat Uncomfortable	Comfortable	Warm and Friendly	A close bond

Comments:

18. Overall, how would you judge your child's progress this year?

1	2	3	4	5
Much less than expected		About what I Expected		Much better than I expected

Comments:

19. How do you feel about the program approach to intervention with your child and family?

1	2	3	4	5
Far too structured and demanding	Somewhat demanding	Pretty Flexible	Very Individualized	Too loose, not enough structure

Comments:

20. Woud you describe the program as:

1	2	3	4	5
Oriented toward the school system	Oriented toward therapy	Oriented toward education	Oriented toward child and family	Oriented toward comprehensive services

EVALUATION FORM-FREQUENCY OF SERVICES RECEIVED

Here is a list of services which the program has made available at various times and some services which may not have been provided. Please indicate how often you received each service by using the following scale. Also, indicate in the second column how often you have perceived a need for this service.

0	1	2	3	4	5	6	7
Never	Once or twice during the year	Several times during the year	About once a month	Several times a month	About once a week	Two or three times a week	Everyday

How many times did you receive this service?	How many times did you feel a need for this service?	
______	______	Opportunity to observe your child in the program?
______	______	Explanation of child's behavior.
______	______	Explanation of your child's test results.
______	______	Explanation of goals and objectives of your child.
______	______	Discussion of your child's progress.
______	______	Training in how you can follow through with activities at home.
______	______	Facilitation in how to play with and enjoy your child.
______	______	Training in teaching and therapy methods.
______	______	Counseling for family problems.
______	______	Suggestions for family problems.
______	______	Help with managing your child's behavior.
______	______	Emotional support or understanding offered by individual staff members in individual discussions.

Frequency of USE	Frequency of NEED	
		Emotional support or understanding through parent groups.
		Suggestions for toys, materials for your child.
		Training for brothers or sisters in how to interact with the handicapped child.
		Information about your child's handicapping condition.
		Information on developmental sequences and what to expect "next".
		Help in formulating realistic expectations of your child.
		Help in long range planning for your child.
		Education on parenting.
		Transportation.
		Day Care
		Respite Care (day or night care for your child, overnight or longer)
		Information on special equipment for your child.
		Opportunities to become involved in school activities.
		Opportunities to contribute to decisions regarding the total program.
		Opportunities to socialize with other parents in the program.
		Involvement in staff in-services.
		Use of the resource library.
		Other:

Please * those services which were very valuable to you.

PARENT MEETING EVALUATION FORM

Circle the number which most reflects your opinion. Feel free to comment.

1. The material presented was:

1	2	3	4
Not at all useful	Not very useful	Somewhat useful	Very useful

2. The depth of material presented was:

1	2	3	4
All I need to know	Pretty good, but I'd like more information	I have enough information but I'd like to know how to use it.	We need much more indepth discussion of this topic. (information and application)

3. The manner in which information was presented was:

1	2	3	4
Boring	So-so	Pretty interesting	Very stimulating

4. I liked the (check one or more)

_______film/video tape
_______discussion
_______panel
_______demonstration
_______role play
_______lecture
_______entertainment
_______refreshments

5. What would have improved this meeting?

6. Suggestions for future meetings:

EVALUATION OF STAFF DEVELOPMENT

1. Indicate the inservice activities in which you have participated. In column 1 indicate the frequency of your participation.

1 = at least once a week
2 = at least once a month
3 = at least once a year
4 = never

In the column 2 indicate the usefulness of this activity to you.

0 = not useful, 1 = not very useful, 2 = useful, 3 = very useful

Staff Development Activity	Frequency	Usefulness	Comment
Seminar			
Lecture			
Discussion			
Conferences			
Workshops			
Audiovisuals			
Demonstrations			
Site visits			
Role play/simulation			
Curriculum Development			
Courses			
Conducting Workshops			
Holding an office			
Publishing articles			
Travel			
Readings			
Classroom research			
Work session at Teacher Center			
On-the-job Training			
Internship			
Teacher exchange			

2. What have you gained from inservice training activities?

1) Awareness (list attitudes or topics about which your awareness is now greater)

____

____

____

2) Knowledge (list topics or areas about which you now have some working knowledge which is greater than the awareness level)

____

____

____

3) Skills (list types of new skills you have gained)

____

____

____

4) Expertise (list areas in which you feel you have sufficient expertise to be able to share your knowledge or skills with others)

____

____

____

Other: ____________________________________

____

____

3. Indicate your overall satisfaction with inservice activities (circle the one closest to your opinion)

1	2	3	4	5	6
Totally Inadequate	Superficial/ Insufficient	Met some needs but not enough	Was pretty good, but not individualized	Was pretty good but not indepth	Comprehensive and individualized

4. How could inservice activities be improved? (check (✓) those with which you agree.)

____more variety

____more applicability

____more individualized

____more incentives

____more time for activities

____recognition of growth and improvement

____higher level activities

____more internal staff exchange

____other (list):